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MILITARY TREATMENT FACILITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

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MILITARY TREATMENT FACILITIES

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Wednesday, February 3, 2016.

The subcommittee met, pursuant to call, at 2:03 p.m., in room 2212, Rayburn House Office Building, Hon. Joseph J. Heck (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOSEPH J. HECK, A REPRESENTATIVE FROM NEVADA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Dr. HECK. I will go ahead and call the hearing to order. Good afternoon, everyone.

Today's subcommittee meets to hear testimony on military treatment facilities, or MTFs, which are the medical centers, hospitals, and clinics that are owned and operated by the Department of Defense and the military services.

For decades, military treatment facilities have been recognized as the foundation of military medical care. They are the primary location for Active Duty military to receive treatment and are the training and education platforms for medical providers worldwide.

Every member of the military healthcare team, me included, has spent time in MTFs. If you have served in the military, chances are you have received care in an MTF for everything from immunizations, to routine health screenings prior to deploying, to witnessing the birth of your child. Depending on the size and location, MTFs provide a wide range of medical services to Active Duty, Active Duty family members, retirees, and retiree family members.

However, military health care, alongside civilian health care, has evolved, and we have seen many changes to MTFs. The certainty that a military installation will have a full-service medical facility is a thing of the past. For example, in 1989, there were more than 500 military medical facilities worldwide, 168 military hospitals and hundreds of clinics. Today, there are 55 hospitals and 360 clinics, for a total of 415 MTFs. Large medical centers, such as Fitzsimons Army Medical Center, once considered an enduring capability, have closed.

The reasons for some of these changes are varied. Health care has largely shifted from an inpatient focus to outpatient settings such as ambulatory surgery and care models such as patient-centered medical homes. Another reason unique to military medicine is the realignment of troop units and closure of military installations, which has shifted the need for medical care among different locations.

So the question we now ask is: What is the future of military treatment facilities? How do they maintain the primary mission of readiness of the force and ready medical professionals? Are MTFs currently situated to support the readiness mission along with the mission to provide care to their beneficiaries?

I am interested to hear from our witnesses about the challenges of running an MTF. How are MTFs different than civilian medical facilities? How does MTF leadership balance readiness requirements and the needs of the beneficiary population, including service members, family members, and retirees?

And, finally, what can we do to ensure the Military Health System has trained and ready providers to support the readiness of the force and provide a valued health benefit to our beneficiaries?

With that, I want to welcome our witnesses, and I look forward to their testimony.

Before I introduce our panel, I would like to offer Congresswoman Susan Davis, our ranking member from San Diego, an opportunity to make her opening remarks.

[The prepared statement of Dr. Heck can be found in the Appendix on page 37.]

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mrs. DAVIS. Thank you, Mr. Chairman.

I also want to welcome our witnesses, and thank you very much for joining us today.

You know, over the past several months, we have met with senior leaders in military medicine who have discussed the policies of providing health care to the force and their families, and we have also heard from beneficiary organizations that represent those on the receiving end of healthcare services.

So today we have this unique opportunity to meet with the four of you, the military treatment facility commanders, three words, but they are all really important, all separate—who execute the policies, interact with the military providers as well as the beneficiaries affected by those policies and healthcare services.

So I look forward to our discussion and hearing from each of you how you balance the requirements of maintaining medical readiness for your providers while providing access to quality health care for your beneficiaries and what can we do to help you in that endeavor.

Thank you all so much for being here.

Dr. HECK. Thank you, Mrs. Davis.

We are joined today by another outstanding panel.

Given the size of our panel and our desire to give each witness the opportunity to present his testimony and each member an opportunity to question the witnesses, I respectfully remind the witnesses to summarize, to the greatest extent possible, the high points of your written testimony in 5 minutes.

The lighting system before you, when you have 1 minute left, it will turn yellow. When you are out of time, it will turn red. I assure you that your written comments and statements will be made part of the hearing record.

So let me welcome our panel: Colonel Mike Heimall, United States Army, Chief of Staff, Walter Reed National Military Medical Center—in the interest of disclosure, I was on staff at Walter Reed from 1998 to 2001; Colonel Mike Place, Commander, Madigan Army Medical Center at Joint Base Lewis-McChord; Captain Rick Freedman, United States Navy, Commanding Officer at Naval Hospital Camp Lejeune; and Colonel Douglas Littlefield, United States Air Force, Commander of the 19th Medical Group at Little Rock Air Force Base.

Colonel Heimall, you are recognized for 5 minutes.

STATEMENT OF COL MICHAEL S. HEIMALL, USA, CHIEF OF STAFF, WALTER REED NATIONAL MILITARY MEDICAL CENTER, DEFENSE HEALTH AGENCY

Colonel HEIMALL. Thank you, Chairman Heck. And I was also on staff at Walter Reed 1998 to 2001. So it is great to have another alumnus of the Georgia Ave. campus.

So, sir, Ranking Member Davis, and distinguished members of the committee, Mr. O'Rourke, it is great to see you again, sir, thank you for the opportunity to discuss the role our military treatment facilities play in supporting military readiness and how we care for our beneficiaries.

I am the Chief of Staff at Walter Reed National Military Medical Center, and, until this past Monday, I served as the Center's interim director. I would like to take a moment to highlight what we at Walter Reed are doing to ensure our staff are well prepared for future deployments and how we are enhancing access for our patients across the National Capital Region [NCR] while we continue to care for America's heroes from around the world.

Walter Reed is the largest MTF in the National Capital Region enhanced multiservice market. Together with the Fort Belvoir Community Hospital and 9 smaller MTFs, we are partnering to improve access to care for more than 245,000 TRICARE Prime enrollees across the National Capital Region.

Today, providers from Walter Reed are seeing patients in nearly every one of those MTFs across our market in order to make care more convenient for our patients, eliminating the hassle of having to fight beltway traffic to come to Bethesda. We are also streamlining functions like appointing and referral management to gain efficiencies and improve access.

My written testimony highlights several of the programs which Walter Reed-Bethesda is internationally renowned for. The Military Advanced Training Center for amputee rehabilitation, the National Intrepid Center of Excellence for traumatic brain injury and psychological health, and the Murtha Cancer Center continue to lead our Nation in developing evidence-based innovations that serve both a critical military medical need but also critical needs within American medicine.

Our co-location with the Uniformed Services University of Health Sciences and the National Institutes of Health allow us to develop partnerships that better integrate education and research into patient care. These partnerships also afford us the opportunity to collaborate with renowned leaders in trauma care, cancer care, and

infectious diseases, improving care for our patients today while preparing our team for the deployments of the future.

And we are also expanding this partnership to include our local and regional Veterans Administration medical centers so we can improve access to care for our veterans. Our veterans are as much a part of the military family as anyone who comes to us for care, and it is a privilege to care for them.

These veterans are also often our most critically ill and complex patients, which exercises and strengthens the same critical care skills our entire team—providers, nurses, technologists, medics, and corpsmen—all need to care for a critically ill or injured service member on the battlefield, en route to a higher level of care, or back home at our MTFs.

Thank you again for the opportunity to discuss these efforts with you, and I look forward to your questions.

[The prepared statement of Colonel Heimall can be found in the Appendix on page 39.]

Dr. HECK. Colonel Place.

**STATEMENT OF COL MICHAEL L. PLACE, USA, COMMANDER,
MADIGAN ARMY MEDICAL CENTER, JOINT BASE LEWIS-
McCHORD, UNITED STATES ARMY**

Colonel PLACE. Chairman Heck, Ranking Member Davis, and distinguished members of the subcommittee, thank you for the opportunity to represent Madigan Army Medical Center and Army Medicine today.

Since 1944, Madigan has been a provider of world-class patient care, an unparalleled education facility, and a state-of-the-art research platform. Madigan cares for over 100,000 beneficiaries with around 5,000 staff members; supports over 250,000 beneficiaries as the tertiary referral hospital for the Puget Sound enhanced multi-service market.

Madigan supports Joint Base Lewis-McChord, one of the Nation's premier power projection platforms, home to 1st Corps, 7th Infantry Division, 1st Special Forces Group, the 62nd Airlift Wing, and a variety of smaller units. Our forces are aligned to the U.S. Army Pacific and are integral to supporting partnerships and exercises in the region as well as operations around the world.

Madigan has a two-fold readiness mission: to ensure our service members are medically ready to deploy; and generating and maintaining ready medical forces.

By collaborating closely with our line commanders, as well as unit medical and dental providers, we have increased the available rate for soldiers in 1st Corps to nearly 91 percent. We will continue to work with our senior mission commander, Lieutenant General Lanza, to identify means to continue to improve the readiness of our soldiers, such as by increasing the availability of physical therapists for injury prevention or through implementation of the Army's Performance Triad.

As an academic medical center and one of only two designated Level II trauma centers in the Army, Madigan plays an important role in ensuring we have ready medical forces. In 2015, Madigan trained 319 individuals in graduate medical education [GME] in 33 distinct training programs. Our residency programs boast a 95 per-

cent 3-year, first-time board pass rate, readily exceeding the national average of 87 percent. Madigan's orthopedics, neurology, and radiology programs' in-service examination performance this year places them in the top 10 percent of the Nation. And our emergency medicine residency remains one of if not the top in the country.

Most importantly, our graduates are prepared through a unique military curriculum which provides them the tools to successfully transition to serve as surgeons in maneuver units or to serve in forward surgical teams or combat support hospitals.

As a hospital commander in Afghanistan, I witnessed firsthand how our GME and related medical training programs provided the capability to achieve our unprecedented 92 percent survival rate despite the increasing severity of injuries sustained in modern combat.

However, the Army cannot focus exclusively on sustainment of trauma skills and surgical capabilities alone. My experience in supporting the 75th Ranger Regiment in Operation Uphold Democracy in Haiti and as a medical task force commander during the Kosovo air campaign shows that Army Medicine must be prepared to support a wide range of crises, from peacekeeping, to disaster relief, to humanitarian assistance.

Military treatment facilities like Madigan are vital to ensure our medical teams are trained, ready, and relevant to provide care globally. Our partnerships with the VA [Department of Veterans Affairs] and the civilian community strengthen our programs by providing a diverse and complex mix of patients to hone our skills for our entire medical team.

I am personally committed to improving the readiness of our soldiers and our medical teams so they can best serve our Nation. On behalf of Team Madigan and Army Medicine, I want to thank Congress for your continued support. I look forward to your questions.

Thank you.

[The prepared statement of Colonel Place can be found in the Appendix on page 49.]

Dr. HECK. Captain Freedman.

STATEMENT OF CAPT RICK FREEDMAN, USN, COMMANDING OFFICER, NAVAL HOSPITAL CAMP LEJEUNE, UNITED STATES NAVY

Captain FREEDMAN. Chairman Heck, Ranking Member Davis, distinguished members of the committee, thank you for providing me the opportunity to share my perspectives as Commanding Officer, Naval Hospital Camp Lejeune, on the role that military treatment facilities have in providing medically ready service members and ensuring an operationally ready medical force. We in Navy Medicine are privileged to care for those entrusted to our care.

Naval Hospital Camp Lejeune is a family medicine teaching hospital located in eastern North Carolina, providing medical support to forces stationed on and around Marine Corps Base Camp Lejeune, to include members of the 2nd Marine Expeditionary Force and members of the Marine Corps Special Operations Command.

The primary reason we exist is to build and sustain medical readiness. At Camp Lejeune, readiness takes three distinct but equally important components.

First, readiness means that we as medical professionals who wear the cloth of our Nation are ready at a moment's notice to deploy in support of our Navy and Marine Corps team. We must be physically, professionally, spiritually, medically, administratively ready to move out at a moment's notice. Our MTFs are the reservoir of forward-deployable expeditionary medical support for our combatant commanders. Nowhere is that better understood than aboard Marine Corps Base Camp Lejeune, where it is common knowledge that no marine has ever taken a hill without a United States Navy corpsman.

Second, readiness means that we ensure our marines and sailors are ready to be the first to fight in any theater of operation and we understand their demanding mission. Several of our clinics are located around the base and are staffed jointly with medical personnel assigned to both hospital and assigned to operational units. This initiative improves access, continuity and quality of care, and provides expanded capabilities for our teams to collaborate during real scenarios, as demonstrated during our recent successful response to two recent mass casualty events following training mishaps.

A third but equally important mission is caring for our families because our team understands there is no surer way to make a combat marine, soldier, sailor, airman, guardsman more ineffective than to have them worry about their family. Family readiness supports force readiness.

We at Camp Lejeune are committed to being leaders in quality, safety, access, and service. NHCL [Naval Hospital Camp Lejeune] is proud to be among the first to employ available technologies to increase how our patients communicate with our providers. From our patient smartphone application, to 100 percent primary care manager use of secure messaging, to strong support of our nurse advice lines, we are ensuring patients have 24/7 access.

Another of our access initiatives is launching our tele-ICU [intensive care unit] project, virtually connecting our intensive care unit with that of Naval Medical Center San Diego; use of digital radiology and telepharmacy throughout our multiple clinics spread out over the 246 square miles of Marine Corps Base Camp Lejeune.

We are proud to note that we have implemented the Centering in Pregnancy Program that offers mothers-to-be a unique group prenatal care model that promotes education and peer-group connections. It has been extremely popular with many of our patients, particularly those lacking built-in support systems, a deployed spouse, or other challenges associated with military service.

It is critical to note the importance of our hospital given the location in eastern North Carolina and the vital role we play in a medically underserved area of our country. There are wonderfully talented and dedicated civilian medical partners in Jacksonville and the surrounding areas; however, our community does not have the medical infrastructure which may exist in other metropolitan areas.

Camp Lejeune's family medicine residency program has received the highest level of certification by the ACGME [Accreditation Council for Graduate Medical Education], has grown by 50 percent, and achieved 4 years of unprecedented 100 percent board pass rate for our residents.

Their re-affiliation with our retired beneficiaries, who have doubled in size in the last 2 years, has really improved the acuity and complexity of cases for our interns and residents and specialists and allowing our team to care for those who have previously served and who deserve the best that this Nation can offer.

An integral aspect of care which has no counterpart in the civilian community is our Intrepid Spirit Concussion Recovery Center. This center offers exceptional support for our service members afflicted with traumatic brain injury [TBI]. A hallmark of the Intrepid Spirit Center is a holistic, integrated, interdisciplinary treatment approach that includes 10 different specialties, to include complementary alternative medicine techniques. Care is tailored to meet the unique needs of the warrior athlete, and, to date, approximately 2,000 of our warfighters have gone through the program, with over 90 percent of them, at least from the standpoint of TBI, returned to full duty.

In summary, we are a critical part of the greatest and most highly capable Navy and Marine Corps team that the world has ever known. Our hospital serves as a readiness platform for the force and families stationed in the area. We will continue to be a forward-deployable expeditionary medical capability while maintaining the highest levels of readiness.

Thank you for your support of military medicine, and I look forward to answering your questions.

[The prepared statement of Captain Freedman can be found in the Appendix on page 59.]

Dr. HECK. Colonel Littlefield.

STATEMENT OF COL DOUGLAS M. LITTLEFIELD, USAF, COMMANDER, 19TH MEDICAL GROUP, LITTLE ROCK AIR FORCE BASE, UNITED STATES AIR FORCE

Colonel LITTLEFIELD. Chairman Heck, Ranking Member Davis, and distinguished members of the committee, I too thank you for the opportunity to come before you today on behalf of the men and women of the Air Force Medical Service.

As commander of the 19th Medical Group in Little Rock, Arkansas, my job includes leading a team of 350 dedicated Active Duty, government service civilian, and contract employees in supporting a population of 44,000 beneficiaries within a 40-mile radius from our clinic.

Of those beneficiaries, approximately 14,000 are enrolled directly to our clinic and receive care across our spectrum of provided services, such as our family and women's health clinic, flight medicine, optometry, and dental clinics.

Some of the more unique services include both public health and bio-environmental sections as well as our aerospace physiology and High Altitude Airdrop Mission Support team that directly support a myriad of U.S. and coalition partners in conducting operations in unpressurized aircraft between 10,000 and 35,000 feet in altitude.

Each day, we strive to provide trusted care to the population we serve while continually looking for ways to provide safer, more efficient care and remain in touch with our patients' needs.

Supporting the mission is our first priority. It is why we exist and where we focus our daily efforts. At Little Rock, this means combat airlift anywhere, anytime. Our actions ensure our Active Duty population are ready physically, mentally, and emotionally to carry out their role in supporting the wing's mission. It also means caring for family members, retirees, and their dependents with the services that we provide. Ultimately, military readiness is community readiness, and leading my team to recognize the role they play in this priority has benefited all involved.

The next priority we focus on is people. Our amazing teammates are how we get this mission done. And we strive daily to treat our patients, family members, community partners, as well as each other with the utmost respect and professionalism. We are committed to resiliency in every area of our lives, which makes us more productive and better teammates. We also look for opportunities within the clinic, wing, and community to grow personally and professionally so that we can continue to become better airmen.

Our final priority is communication. There is no substitute for clear and concise communication at all levels, which allows our team to function at its peak. We are always looking for opportunities to improve our communication methods by listening more than we speak and utilizing different sources of information across our available spectrums to get pertinent messages to those we support.

By focusing on these priorities, we are committed to supplying safe and high-quality health care to all those we serve. While the pursuit of this may look different at each location, the Air Force Medical Service will provide trusted care anywhere as we strive for peak readiness and the highest reliability in all we do.

Thank you for the opportunity to speak on this matter and for your continued support.

[The prepared statement of Colonel Littlefield can be found in the Appendix on page 70.]

Dr. HECK. I thank you all for your testimony.

We will now move into rounds of questioning. Each member will be limited to 5 minutes. We will go in the order of arrival prior to gavel. Hopefully, because I know I have several questions, we will have time for multiple rounds.

And I will start.

Colonel Heimall, you know, the interesting thing about Walter Reed is that you are under the command of DHA [Defense Health Agency] and not a service. Can you give some insight as to how that works, answering to the Defense Health Agency as opposed to a service sector? And, you know, do you see pros and cons to having that type of an alignment?

Colonel HEIMALL. Sir, from a functional alignment, based on my experience commanding within Army Medicine, DHA really functions like a regional medical command or a regional health command for us. That is where our resourcing comes from; it is where our policy guidance comes from. And so it is really not much of a different relationship between Walter Reed and the National Capital Region Medical Directorate and the Defense Health Agency.

I think some of the challenges with the way we are organized is, within the National Capital Region Medical Directorate, Defense Health Agency only operates two MTFs. And so when we look at resourcing, when we look at allocation of civilian hiring caps that are in place to allow us to bring civilians on board, we don't have the degree of flexibility that Army Medicine, Navy Medicine, or Air Force Medical Service have, given the size and the scope of their regions.

We have about 4,500 civilian authorizations across the National Capital Region Medical Directorate. I will compare that to my time at William Beaumont Army Medical Center in El Paso, when Western Regional Medical Command at the time had over 11,000 authorizations. And so it makes flexibility in hiring and shaping our workforce much more challenging.

Dr. HECK. Great. Thank you.

Colonel Place, you mentioned that Madigan was a Level II trauma center, one of only two within the inventory. Are you integrated into the civilian EMS [emergency medical system] system, and do you receive civilian casualties from trauma into your trauma center?

Colonel PLACE. Yes, sir, absolutely. We are part of the Tacoma Trauma Trust. As that, we back up two civilian hospitals downtown. We average about one or one and a half activations of our trauma team every day. So we are basically the backup 365/24 hours a day for anyone else.

Dr. HECK. And how critical would you say that that integration with the civilian trauma center is in being able to maintain the trauma skills of your staff members?

Colonel PLACE. Sir, I think it is enormously important. We have only one Level I trauma center down in San Antonio. I think it is important that we routinely see trauma in order to maintain those skills for not just the surgeons, because they are relatively easy to get to a trauma center to go do trauma, but, as you know, it takes a lot more than just the doctor to be able to do those things. You need to have the ER [emergency room] trained well; you have to have anesthesia and the PACU [post operative care unit] and the ICU. All of those need to have training, the pulmonologists, you know, the respiratory techs. Everybody needs to be part of that.

So if we don't see any trauma, that is a challenge for us. And I personally would like to see more because I think that adds to our capabilities when we go to war.

Dr. HECK. Could you summarize how that relationship was established between Madigan and the civilian hospital system?

Colonel PLACE. So, sir, I am not familiar with the actual history of that. I understand it was more than a few years ago that that was put in place. So I can get back with you for the details if that is important. But right now we are in discussions with our counterparts down there to make sure that we are all fulfilling our roles and responsibilities as part of that.

[The information referred to can be found in the Appendix on page 83.]

Dr. HECK. And as part of that relationship, do some of your providers rotate out to civilian hospitals? Or is it all done based on the trauma patients, civilian trauma patients, coming to your facility?

Colonel PLACE. Yes, sir, we have some external resource sharing agreements where we send some of our folks downtown. Right now, probably the most dramatic is our cardiothoracic surgeons. They go downtown to perform surgeries there to maintain their skills. We don't have enough caseload within our population to really allow them to maintain their skills, so we let them go downtown, with preferential treatment of our beneficiaries. But even so, we end up doing some VA cases and things like that downtown.

Dr. HECK. Great. Thank you.

Since my time is almost up, I would rather not shoehorn an answer into my next question, so I will wait for the next round.

Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

And, again, thank you all for being here.

We have heard from a variety of sources, certainly, as we have worked through this over the last number of months, that access to healthcare providers is a challenge for some of the MTFs. And I wonder if you could talk about how you monitor or you balance the access to care for those depending on services.

And when you think about additional services that have to be increased, in what area is there greatest demand? And how—do you track that so you have a sense of where that healthcare dollar is being spent?

As you may know, there was a study last year, a Shelton study last year, that really looked at some of the contracted services, and they were pretty high, 70 percent, versus the MTF.

So can you talk a little bit about that? And how do you do that? And what do you know about that, in terms of trying to provide that additional resource?

Colonel HEIMALL. Well, ma'am, I can tell you within the National Capital Region we look very closely at where our patients are going to get their care and what we are paying for in the private sector, with the intent of trying to recapture as much of that care as we can.

Every time we treat a patient inside of our MTF, there is value in maintaining the skill level of not just the physician or the mid-level provider who is seeing that patient but the entire care team around that provider.

Additionally, if we have the capacity to see the patient and we send them downtown, the taxpayer has really paid twice for that care. And, as a taxpayer, I don't like doing that, and I am sure not many others do.

Within the National Capital Region, the needs really revolve around access to services like dermatology, gastroenterology, podiatry, and physical therapy. And I think the rest of the members will say physical therapy has been a challenge for most of us across the military services.

And so you look at innovative ways, now, how can I bring that care back into the system. And, in many cases, what we are doing at Walter Reed and Fort Belvoir is looking at how we can take our providers to where the patient lives and works. And so we have gastroenterology providers living and working at Fort Belvoir and Fort Meade every day. The Air Force has assigned an additional gastroenterology provider to Malcolm Grow who actually works at

Fort Belvoir Community Hospital every day so that we can meet that demand.

And we are justifying additional resources in the market not based on what we are doing at an individual facility but what the market needs to be able to take care of the patients that are enrolled to us.

Mrs. DAVIS. Thank you.

And how has that medical dollar been spent then as a result of what you are trying to do? What have you seen that is different?

Colonel HEIMALL. Well, I think one of the things we have done in the last year in the National Capital Region is we have lowered our per-member, per-month cost significantly, about \$90 per patient per month. And that has really been a result of trying to bring that care back in-house and better utilize the capacity that we have.

I am interested to see what happens. We have just hired 11 physical therapists for the entire market, and we are placing those physical therapists at the MTFs where that care is being referred to. So it will be interesting to see how much care we can recapture and whether or not we can make the care more convenient for the patient.

It makes no sense for somebody from Pax River, for example, to drive to Walter Reed for physical therapy three times a week if we can provide that service much closer to Pax River.

Mrs. DAVIS. Great. Thank you.

Anybody else want to respond?

Captain FREEDMAN. Congresswoman, I would like to say, too, as Navy Medicine and the MHS transitions from health care to health, access, service, these are indicators of health—very, very important.

So we look at establishing that trust with the patient in a patient-centered medical home model to ensure that it is easy to get access. We monitor every single morning, making sure that our templates are built for open access for our patients. We are providing new and innovative ways for our patients to contact us, through nurse advice line, through secure messaging, through our patient smartphone application.

We want to make sure that we establish that, because if you need to be seen today, our covenant is that we will see you today. And that is the trust that you build into your patients so they don't seek care in the emergency room. Not that that is not good care, but that is not great primary coordinated care that leads us to health.

We also work very closely with our managed care support contractor who manages our network of facilities. And if we see that there is an indication for additional resources to be brought back to the direct care system, we work very closely with them to do so.

Colonel PLACE. Ma'am, I would like to add, as well, yes, we monitor all those things very, very, very closely. We have all kinds of briefings related to that.

But I guess the take-home message, from my perspective, is the metrics don't tell the whole story. If you call today at Madigan, the average time until you are seen for an acute appointment is .6 days. The metric that we use for third next available appointment

is 1.6 is what that comes out as. But if you call today, most of the time we add you on. We just say, come on in, we will take care of you. So that is really what I want to get to in terms of access rather than how many appointments do we have.

In terms of the whole dollar figure, we recently went through and kind of reviewed how we do on 37 different kinds of service lines, so gastroenterology, pulmonology, and so forth, that we have. For the multiservice markets, the 250,000 beneficiaries, for 25 of the 37 service lines, more than 85 percent of the care we provide inside the direct care system.

So, yes, ma'am, we look at the value for healthcare dollars. When it makes sense for us to do it inside, we make that business case analysis and we try and provide it internal. If not, if it is more cost-effective to do it through a network provider, then we go that way.

Mrs. DAVIS. Okay. Thank you. My time is up.

Dr. HECK. Ms. Tsongas.

Ms. TSONGAS. Thank you, Mr. Chairman.

And welcome.

As you all are speaking, I am reminded of I was a recipient of treatment in a military treatment facility in my early teens, as was one of my sisters. My father was a career officer in the Air Force. And I have always appreciated the great care we received for not insignificant problems. One was in an MTF here in the United States, another when we were stationed abroad. And in both places, we got such great care. So I thank you for that, as a family member. And I am sure, as we certainly hear from our military families, how important that is.

I do have a question related to the fact, the ever-growing numbers of women that are now currently serving in the Active Duty. And I am curious, as this population is increasing, how well able you feel you are able to serve them as they are in this Active Duty status. And are there shortcomings and ways in which we could be more helpful?

And I will start with you, Colonel Heimall.

Colonel HEIMALL. Ma'am, I think we have had about a 10-year head start on some of the other Federal systems in how we manage women's health. Within Walter Reed, we have a women's health clinic, and there is a range of programs that are available. But we also have the luxury of having an obstetrics and gynecology residency program that allows us to provide a higher level of care for women who are serving, as well as for retirees and the veterans that come to us.

I think one of the gaps that we have right now—and it is a matter of developing it, and we have just started developing the program about 6 months ago at Walter Reed, is a trauma program for women who are suffering from, and men—who are suffering from sexual assault trauma. While trauma is the same from an emotional standpoint, the way we manage that within groups and the therapy we provide really needs a different touch. And so creating an intensive outpatient program for victims of sexual assault is really, I think, a needed service as we go across MTF to MTF.

Ms. TSONGAS. Is that a resource issue or an approach issue? How would you define the shortcoming?

Colonel HEIMALL. I think it is multivariate. It is an issue of recognizing the need, resourcing it, and then making sure you have the people who have the experience to be able to implement the program.

Ms. TSONGAS. Thank you.

Would others like to respond?

Colonel PLACE. Ma'am, I agree. We have had a little bit more experience with this, and as a former operational medicine consultant to the surgeon general, I would say we have even a lot of experience going to war with women, which has, I think, given us some perspectives and some understanding of what those challenges are.

I don't think we have it perfect. I think there are some things that we can do. But I think they are more tweaks to the system rather than big gaps that need resources or major renovations of how we approach women's health.

Ms. TSONGAS. And as women go to war, how would you describe the challenges you have?

Colonel PLACE. So there are a number of things that we look for in terms of hygiene, in terms of privacy, in terms of making sure that we balance security with lighting systems and so forth versus the risk of sexual assault and things like that. There are a number of small factors that come up. But those are things that we have to mitigate the risk against rather than create new programs, I think, from my perspective.

We have a very active women's health service line at MEDCOM [Medical Command] that helps us review these things and implement new methodologies. Recently, I will just give you an example from Madigan. An important women's issue is breastfeeding, and we have actually purchased four pods for breastfeeding within Madigan because we didn't have locations that we thought were reasonable and accessible for women to breastfeed in. So we purchased them, we sent them up, had them advertised and so forth. And we are helping the rest of the installation figure out where to put them, how to utilize them to make them effective for our female soldiers as well as for us, the patients that come there.

Ms. TSONGAS. And we are glad to see Secretary Carter recognize that this is something that has to be dealt with across the services, not just in the MTF environment but in general.

Colonel PLACE. Yes, ma'am.

Ms. TSONGAS. Would others like to comment? I have just a little time.

Captain FREEDMAN. Congresswoman, we are proud at the Naval Hospital Camp Lejeune to have many initiatives.

We have been designated, applied for and designated as a three-star facility by the North Carolina Maternity Center for breastfeeding-friendly institutions.

We have started a Centering in Pregnancy Program that I talked about in my opening remarks; that, according to the Centering Healthcare Institute, we have the most number of participants in the Nation, not just in DOD [Department of Defense], with 27 active groups that are going through this group prenatal care program.

And I am blessed in leadership with a partner, my executive officer, who is also a women's health nurse practitioner, to make sure that we provide care for all our warfighters and their families.

Ms. TSONGAS. Thank you. My time is up.

Dr. HECK. Ms. Stefanik.

Ms. STEFANIK. Thank you, Mr. Chairman.

Thank you to the panelists for your service today and the sacrifice of your families.

On Fort Drum, which is an Army installation that I represent in my district, we have a clinic as opposed to a hospital on post. Guthrie Army Health Clinic and the MEDDAC [Medical Department Activity] that oversees it supports over 14,000 Active Duty soldiers and 16,000 military family members. Due to this unique relationship, the MEDDAC at Fort Drum partners with the community to ensure that the highest quality of care is provided to all patients.

So I wanted to turn to Colonel Littlefield.

What are some of the unique challenges you have faced while partnering with civilian provider networks for services that you are unable to provide? And would you consider a model similar to what you have at Little Rock Air Force Base to be as efficient as other installations that have full hospitals with inpatient care on post?

Colonel LITTLEFIELD. Thank you, ma'am.

I think the opportunity is, or the word is "balance," too. It is something, when we are looking at access, again, a clinic compared to a bedded facility and what we offer, we are in constant communication with our community partners. Some people don't consider Little Rock as robust, but that is one of the things that I have found. Their civilian network is quite robust. Now, there are some specialty areas, particularly when you get in the pediatric ranges, some of the mental health services that need to be provided, there are long wait times there. But, overall, I have been very pleased with the availability of services.

But we partner with them. We do things from holding provider collaborations every year to invite our partners in, meeting with them, developing relationships. We have been able to send some of our providers down to the Arkansas Heart Hospital, seeing open heart procedures and those types of events.

So we are always looking for opportunities to partner. And I think with us being the only Active Duty facility in the State of Arkansas, that is where we are headed, is that we need that partnership for those things that we can't provide. We will capture everything we can, bring it into our facility to keep the skills up of our team members, but we rely on our community partners.

Ms. STEFANIK. Thank you for that.

Does anyone want to comment on that question?

Go ahead, Captain Freedman.

Captain FREEDMAN. Thank you very much, Congresswoman.

We are blessed in eastern North Carolina to have a fantastic, supportive community in Jacksonville and the surrounding area, where they understand the importance of the Marine Corps and the Navy team and what it does for the defense of our Nation.

So our partner facilities in the civilian community have been wonderful for us. We have expanded some enhanced resource-sharing agreements with our local hospitals for a dual diagnosis pro-

gram for dependency and behavioral health. We have our local hospital that provides operating room space for us as we undergo renovation of our operating room spaces. We have a great medical center in Vidant Medical Center that we have entered into an agreement with to allow our corpsmen, our nurses, and our physicians to be able to go up there and get training that we may not see in our institution.

So it is a true community. And I think it's understanding the mission. And I think no one does it better than Jacksonville, North Carolina.

Ms. STEFANIK. Thank you very much.

Any other comments?

Colonel PLACE. Ma'am, I would just offer that I think it depends. You know, "balance" is a way to put it, but what we would like to do, and I think we do a pretty good job of it, is finding the talents and capabilities in the civilian community, and if it makes good business sense to capitalize on, then let's do that. If it doesn't, then let's do it inside the facility with, you know, taxpayer dollars.

So if the capability is there and it is a high-quality capability, then, by all means, we ought to do that.

Colonel LITTLEFIELD. Ma'am, I agree with what the other panel members have said. I think you to have to look at, first, is there a compelling readiness reason why I would want to offer that service—inpatient care, complex surgeries, intensive care, for example, the things that Guthrie gets from the civilian community—in my MTF at a particular location. And health care is still a very local phenomenon, so every base has a different community and different assets in that community to support them.

And so, if that case is there, we build it there. If that case isn't there, then where can we get that in the civilian community, and how can we build the partnership to make sure that works smoothly.

Ms. STEFANIK. I appreciate those comments. And we have had success stories in the broader Fort Drum community, partnering, for example, with River Hospital, with a very high-quality PTSD [post-traumatic stress disorder] program. That is an example of identifying a need and working with the experts and the practitioners who are within the community.

So thank you for your testimony today, and thank you for the thoughtful answers.

Dr. HECK. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

And I want to thank each of you for your testimony and your answers to our questions.

And, Colonel Heimall, I would just like to thank you, especially, for your service, because I am most familiar with it, when you were the commander at William Beaumont Army Medical Center. And during that time, when you were both commander and I was the Representative for the area, I probably had 40 public townhall meetings, you know, where everyone was invited, no holds barred, any issue or topic, and you were there at every single one of them, whether Army Medicine or veteran care was the subject or not. And I think that sends a very powerful message to the community

about your interest and involvement in the community at large, especially veterans' care as connected to Active Duty military care.

And then, to that point, you did a tremendous job working with our local VA, which is physically conjoined with William Beaumont, while overseeing a billion-dollar construction project for the new William Beaumont. So I can't thank you enough for what you have done for our community, for the veterans there, for the Active Duty military and their families.

You mentioned in your testimony the need to ensure that there is a continuum of care for Active Duty service members into the transition to civilian life when they are veterans. And, anecdotally, in El Paso, I will often encounter veterans who served at Fort Bliss, which is served by William Beaumont, who said that for their mental healthcare needs, while they were Active Duty, they were met almost without fail, without complaints. If their prescription for their PTSD required seeing a therapist once a week, they were seen once a week. And, by contrast, in the civilian world, treated by the VA, maybe they get in to see a therapist, maybe they don't get to see anyone at all. And we were later able to confirm that through a survey that found that one-third of veterans in El Paso could not receive mental health care despite trying.

So how do we fix this? If we are able to recruit and retain or make use of mental healthcare providers who are in active service and do so effectively, how do we ensure that there is consistency and continuity in that care once that service member becomes a veteran, at a time when we have, officially, 22 veterans a day taking their own lives? And I know for a fact that that level of suicide is connected to care that is delayed or denied at the VA. How do we fix this? What have you learned at Walter Reed, at William Beaumont, in collaboration with the VA, that would allow us to begin to be more effective in combating this?

Colonel HEIMALL. Sir, first, I want to thank you for your support and your district staff. The partnership we had there I think made my 33 months there incredibly successful and really helped me navigate a number of problems that could have derailed a lot of what we were trying to do. And that was the partnership that we had, I think, that really made that a success.

Your question is very well put. Particularly in the area of behavioral health, there are a number of areas where we have the ability, I think, to help the VA with access to care. And we certainly try to do that at Walter Reed every day. But, in El Paso, one of the areas I struggled to be able to support the VA was in primary care services and behavioral health. And I think that is true at a number of our facilities and certainly true at Walter Reed, though we do have a little more flexibility with the inpatient capabilities that we have.

There is a national shortage of behavioral health providers. It is not unique to the military, unique to the VA. I believe, nationally, we are not filling all the residency seats for psychiatry across the country. We are looking for innovative ways to grow psychology programs, internship programs, et cetera. And so we have to do something to address the supply at the national level.

We are all competing for the same providers, and often what happens is we wind up into a bidding war with the VA or with our

civilian counterparts over how we retain providers. In our experience in El Paso, it was very common to have someone work for us for 2 years and then slide over to the VA for a couple of years and then come back to us 3 years later. And we have to do something to increase the pool so that we can meet the demands of our patients.

Mr. O'ROURKE. And it sounds like there is going to be another round, so I will ask this again, and we will include the other colonels in the response. But I think my point is that you were somehow able to figure that out.

And, you know, very often I heard the reverse of the scenario you described, where it is DOD that is hiring away from the VA, and the VA felt like it couldn't compete on salary or price or benefits or retention bonuses or whatever is provided.

So I understand there is a scarcity, but some are able to receive care amidst that scarcity while others do not. And I would just think that if we are treating the same person for the same condition and we are able to do so successfully on this half of the divide, there has to be some way, perhaps even using the same providers, to continue that care once they are on the other side of the divide.

So I am out of time, but I would like to come back to this if there is another round. Thank you.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. Thank you, Mr. Chairman.

You each are overseeing facilities within one of the branches of our Defense Department. And I am interested whether that matters, that you stay within that particular branch, or whether all healthcare facilities within the MHS [Military Health System] could be managed together, which has been recommended.

And I would like to know, beyond parochial concerns, I would like to know why you think one or the other is more effective for our primary objectives.

And we will start with you.

Colonel LITTLEFIELD. Yes, sir. Thank you.

I think, at the end of the day, I think my panel members would agree, we are pretty much blind to who we are providing care to, as far as our sister services. We treat, you know, Marines, Navy, Army all across, even in our facility. And so I think that is the bottom line, is the provision of care and excellent care and how we do it.

Mr. MACARTHUR. What about on the other end? Does the oversight within a particular branch matter?

Colonel LITTLEFIELD. Ultimately, I don't think so. I think providing the care, maintaining the readiness for our members, maintaining the readiness for our team members themselves, the medics that need to go out and be ready, and maintaining the care for our family members, dependents, and retirees is the factor that we are looking into.

Mr. MACARTHUR. Okay. Thank you.

Captain FREEDMAN. Congressman, thank you for that question.

In Navy Medicine, as we move forward with readiness, jointness, and value, there are many initiatives that are taking place where we are doing best practices and sharing of resources. We started in Naval Hospital Camp Lejeune an Eastern Carolina Healthcare

Consortium, where we have brought together the leaders from Womack Army Medical Center, Seymour Johnson Air Force Base, their clinic there, as well as the VA, to see what we can do to better coordinate care and share resources.

However, there are some service-specific things, and the important part of that readiness mission can't be overstated. We are embedded, and the Navy-Marine Corps relationship is so strong. We go to combat together. We have to understand each other's operations and missions, and we have to be trusted partners in leadership.

And aboard Marine Corps Base Camp Lejeune, we are very fortunate to have incredibly strong leadership, but bring us in on a lot of decision-making that occurs right there on that Marine Corps base, brings that Navy hospital, makes sure that our training is together, our providers work together, they go to war together, they come back together. And there are a lot of specific service-related times where Navy Medicine is called for the Navy-Marine Corps team.

Mr. MACARTHUR. So that service alignment matters is what I hear you saying.

Captain FREEDMAN. It does, sir.

Colonel PLACE. Sir, I think I am in a unique position. I am in a multiservice market that has Army, Navy, and Air Force in it. So Joint Base Lewis-McChord, "McChord" is for McChord Airfield, so there is the 62nd Air Wing there, kind of an important unit in the Pacific Northwest, as well as Naval Hospital Bremerton and Naval Hospital Oak Harbor.

So I am the tertiary referral hospital for the two Navy facilities and actually provide facility space and oversight and IT [information technology] and logistics and so forth to the Air Force facility that actually is part of a wing of a clinic that we have up on McChord Field, on that side of the base.

So I would answer it this way. The clinical care doesn't matter. So when you look down from us, it doesn't matter. It is doctors and nurses and so forth applying their skills. That is consistent across all of us. We have the same measures for quality and safety and so forth.

Where it gets a little bit unique is then, when we talk to line commanders about, you know, what does readiness mean and how do we get there and the nuances of the mission, that becomes important, that we speak that language. And there is some service identification with that.

The bigger challenge really, I think, for all of us is that we need consistency from us up for policy funding, all the rest of the things, that if they change a lot, that becomes a problem. And there are some very unique things about each of our services in how we receive that kind of guidance and information.

So I think, from here up, it gets a lot more complicated, but from where we are down, it is pretty straightforward. It is clinical care. And we can do that regardless—

Mr. MACARTHUR. Just so we have time for the—

Colonel HEIMALL. Sir, my situation is a little bit more complicated than Colonel Place's, in that we are a joint facility, and I do not have any of the traditional command authorities over the

Army, Navy, or Air Force personnel that work at Walter Reed on a daily basis.

And one of the things that I have learned is, as you get more senior and your organizations get larger, you rarely have all the authorities that you want to do your job effectively, and the premium is built on relationship-building and consensus-building to accomplish the mission.

And that is really what we have done, I think, exceptionally well within Walter Reed and the National Capital Region Medical Directorate, given the fact that, as a Defense Health Agency subordinate, we don't have those traditional authorities that my counterparts at the table do have.

Mr. MACARTHUR. Your dilemma sounds a lot like Congress.

I yield back.

Dr. HECK. Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you.

And thank you to our panelists.

Recently, there was a study that shocked me and probably many of my colleagues, that the child abuse among members of our military is much higher than the national average. We are going to have a hearing on that, I believe.

But I am curious what is being done within the various services in terms of providing specifically mental health services in child abuse cases.

Colonel PLACE. So, ma'am, one of the things that we are looking at at JBLM [Joint Base Lewis-McChord] is that very fact. We actually have a higher-than-expected rate of domestic violence in our units. So General Lanza has charged several of us to figure out what to do about it and—

Ms. SPEIER. I am talking about child abuse.

Colonel PLACE. Yes, ma'am. I am talking about domestic abuse of all sorts, both spouse as well as child.

Ms. SPEIER. Okay.

Colonel PLACE. And, with that, we use our Family Advocacy Program principally in order to identify families and get them into care.

We also have a Child and Family Behavioral Health System that we use. We have resources specifically identified to assist with that particular problem, along with all the other behavioral issues that we have for young children.

Ms. SPEIER. Anything else?

Captain FREEDMAN. Congresswoman, aboard Marine Corps Base Camp Lejeune, we are a partner with the Marine Corps Community Services [MCCS] that, in addition with our Navy Medicine assets, provides training and resources so we can get to the prevention of this problem.

We have embedded MCCS family life counselors that enter our clinics, as well, to make sure there are seamless handoffs for cases that are too significant or clinically important for the Marine Corps Community Services to handle so there is a seamless transfer there.

So there are training opportunities and, I would say, embedded partnership with our other services.

Ms. SPEIER. I guess what I am asking is, to me, this is a crisis. It appears that, if it is seven times higher, I forget what the figure was, but I think it was something like seven times higher than the national average, we have a problem, and what we have in place isn't enough.

So I guess my question is more about are we redoubling our efforts, are we doing anything differently than we have been doing.

Colonel HEIMALL. Ma'am, I think we are always looking for opportunities to change how we are doing and deliver the care that is required to intervene in these cases better than we have in the past.

And the parallels within our child and adolescent psychiatry community, as well as the adult behavioral health community for the offenders, is how do you develop programs that meet the needs of the victim, change the behaviors of the offenders, and get at the root causes of what is leading to the abuse.

Some of it requires criminal prosecutions, and those are run through our service-level detachments. Again, these commanders have the authority to prosecute that within their own ranks. We run ours through Army, Navy, and Air Force at Walter Reed.

But my biggest concern in my current role is how do I get the emotional and clinical support to the victims, to the support system around the victims, and if the behavior from the offender is related to something like a combat experience or other traumatic experiences, how do we get help to the offender as well.

Ms. SPEIER. The issue of chronic traumatic encephalopathy [CTE] is real. I have been doing some work with Dr. Omalu, who is the coroner who really exposed the issue and the impact that it is having on football players. He has also now looked at the brains of veterans and has developed a technology of being able to do MRIs [magnetic resonance imaging] and do the screening on living persons.

And it would appear that within the military we have a serious issue relative to CTE. And I am wondering to what extent we have done anything to start to screen those who are serving who suffered sub-concussive or concussions and what steps we are taking to try and address that.

I am running out of time, so maybe, if you can't answer it in 21 seconds, you can do so—

Captain FREEDMAN. Congresswoman, our Intrepid Spirit Concussion Recovery Center has partnered with Team TBI [traumatic brain injury] and the University of Pittsburgh to share resources, to share data, to share best practices. So I think this initiative may open up some doors to be able to help our warfighters and then address this problem.

Ms. SPEIER. All right. I would like to talk to you further about it at some point.

Thank you.

Dr. HECK. Okay. We will begin a second round of questions.

Understanding the importance of trying to recapture beneficiary care into the MTFs from a maintenance-of-readiness perspective for the healthcare provider so they have that broad array of diverse cases, one of the things that we are wrestling with is how do you incent the beneficiaries to come back into the MTFs.

In other hearings that we have had with beneficiary stakeholder groups, one of the concerns that was expressed is that, you know, a beneficiary doesn't like necessarily having a military medical provider, because when that person PCSes [permanent change of station] or they get deployed, they are starting over with another, you know, military healthcare provider.

The other issue that was raised was the inability to get a timely appointment at an MTF.

So how would each of you address those two issues? What do you think it would take to incent beneficiaries to come back? How do you address the issues with the relatively transient nature of military healthcare providers and the capability within the MTF to actually expand access if we get more beneficiaries to come back in?

And I am going to start with Colonel Littlefield since we always go this way and you tend to get left out.

Colonel LITTLEFIELD. Thank you, sir. I appreciate it.

Again, I have mentioned the word "balance" before, but being a clinic, it is something that we always have to be looking at. We work closely with my staff, my chief of the medical staff in particular, to look at our patient balance; how many retirees, what is the acuity and the complexity of care that we can provide for the provider mix that I have in-house too.

I think some of it is communication. That was one of the priorities we mentioned. But talking to the community partners, we go out to the chamber of commerce meetings, we go out in the community, those provider collaborations, and talking to the members that are out there and letting them know the services that we have and can provide to allow them to come back in if that is allowed.

So we maximize everything we can. We fill up our appointments. But we also focus on the access to care and keep that as a priority, to make sure we can get them in. It is not good to advertise services and then not be able to get them to that.

Captain FREEDMAN. Chairman, I think that this is where the MHS and Navy Medicine is particularly well-suited to take care of this issue. The nature of our demographics, our beneficiaries, they are transient, as well, as they change duty sections or duty stations multiple times in a career. We are blessed to have a system of care that may be unlike anything else in civilian medicine. Our medical records systems talk to each other. So even if they go to one service to another or one institution or another, there is some continuity in that.

Patients want to come back to us because we are set up not to produce health care but produce health. We are looking at things differently. Our remuneration system is different so that we are perfectly focused and aligned right now to be able to look at outcomes. Patient-centered care is getting them to partner in their own health care.

And then with generational challenges or generational differences, looking at how access to care is different. What does that mean to some of the millennials? We are using our smartphone technology. We are using virtual messaging. We have appointments that are booked on our providers' schedule that are just talking to patients virtually. Evidence-based research has shown that these

cohorts of patients that are connected with their doctors do better in many of our health metrics.

Our quality is great, and no one is going to care more than our providers.

Dr. HECK. Colonel Place.

Colonel PLACE. Sir, I agree with the idea of what is access. I think we have to broaden our horizons a little bit and recognize that different people want different things, and it all gets lumped into this concept of access. Some of them want secure messaging. Some of them want to have a nurse advice line; they don't want to come in at all. Others really want to have that face-to-face, doctor-patient touch to happen for them.

But I think the biggest thing is that our veterans, our retirees, and our soldiers and their families, quite frankly, want to be part of us. We are the same. You know, we are brothers and sisters in arms. They are our families too. So what I am trying to do and I think is most important for us to do is to celebrate that, to change the culture from, you know, it being difficult to get in to say more that we want them here and we embrace each other.

You know, we have the opportunity—I tell my staff this all the time—we have the opportunity to have the best job in the world because we get to take care of America's sons and daughters every day. And we get to work with people like us who really care about them because most of them have some sort of affiliation with the military in some way, shape, or form. Many of them could probably make more money going to a different civilian job rather than staying with us.

So I am really trying to change the culture to say, you know what, this is a special place where we do special things for special people that makes a difference to our country. And once we start having those conversations, my experience has been the retirees say, you know what, I will do it, I want to come be part of that. And our staff actually celebrates when they do and say, you know, "Sergeant Major Retired Jones, we are glad you are back with us today. We are happy to provide you care." I think when we do that that a lot of those other issues will really go away.

I was in with the other Representative Heck this morning, and he told me, for us, essentially, our complaints about lack of access have declined precipitously recently. And I hope that is related to some of that culture that we are working on that really changes the dynamic, I think, of those interactions.

Dr. HECK. Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

You know, I think you just sort of capped off, brought together, I think, Colonel Place, I mean, you know, what is the problem we are trying to solve here. We know that the affiliation is critical and combined with culture and tradition and a whole host of other things. And, at the same time, we have a lot of stakeholders out there who do think that there are some changes that should really be made. You have attacked a number of those, I think, over the last, you know, few years, and we have certainly seen changes as many of our men and women have returned home. We are not in the same OPTEMPO [operational tempo] that we were.

But, you know, if you could change something, if you really felt that there is something there that does need to change, not because people are critical or because, you know, you think you just have to do it because somebody is asking for it, but, you know, is there something that really is important? Because, in many ways, I think, we come back to arguing the status quo a little bit even though that status quo is changing somewhat; it is being defined differently.

But, you know, is that important? I mean, do you think there are some things that absolutely should change?

Colonel PLACE. So, ma'am, let me start this way. I have a fair amount of operational background. I was at a combat support hospital in Afghanistan. I was division surgeon, 101st, at the start of the war in Afghanistan. So I have seen what happens. I am enormously proud of my colleagues up here and all that we represent to achieve that 92 percent survivability rate. When I was in Afghanistan, 98 percent—98 percent of the people that came to us alive left us alive. Enormously proud of that, unprecedented in the history of war.

So I would just urge caution before we begin thoughts of changing that system. I think it works pretty well.

Can it get better? Absolutely, ma'am. I believe that we do need to have more trauma, more diversity, complexity, acuity in our system. It is very hard to have complex surgical cases when you have young, healthy people. So we need to figure out ways to make that happen. But in terms of dramatic changes, no, ma'am, I don't think at this point that I am convinced that that kind of thing is necessary.

Do we have to have better access? Absolutely. We have two community-based medical homes to try and get to where our patients are. We are trying to expand physical therapy at those locations to make it more convenient. We have school-based medical homes, or school-based health clinics, rather, that we are putting in the middle schools and high schools to actually have the kids get care there so they don't have to come out of school.

So I think those are all, you know, innovations that are going to help us in this process. I think we can do those without wholesale change of the system.

Mrs. DAVIS. Uh-huh.

Anybody else want to comment on that?

Just to follow up really quickly, whether or not we have some more organized ways of helping, you know, for lack of a better term, moonlighting for our men and women to have more formalized connections within communities. There are plenty of communities that do that, but it is more on the initiative of the individual.

Colonel PLACE. Ma'am, do you want me to answer that or—

Mrs. DAVIS. Well, let me just make sure, if you want to just—

Colonel HEIMALL. Ma'am, I think, you know, from a moonlighting standpoint, that is really great for the physician that goes out and is able to practice their trauma skills in a Level I trauma center on a weekend or when they are taking leave, but it doesn't exercise the team that takes care of that patient when the surgeon finishes in the operating room. The operating room nurses, the ICU nurses, the respiratory therapy techs, the folks that manage the blood

bank and have to get blood into the operating room during that case don't get to practice their skills.

I think a better model is bring as much of that trauma into the doors of our major facilities as possible and co-locate our deployable platforms, the combat support hospitals, forward surgical teams, the Navy FRSSes [forward resuscitative surgery system] at those locations where they can practice those skills every day. But we have to be careful in how we do this.

And I think it gets to Chairman Heck's question, as well. When we make that commitment to a community, whether it is to take our surgical teams and embed them in a civilian hospital or to promise to provide Level II, Level I trauma care inside our facilities, the next time the kinetic activity in the battlefield picks up, are we going to be able to sustain that commitment to the community and to those retirees, family members that we have brought back into our system? And we have to be very, very careful that we do not overpromise, because the first time we sever that relationship, we lose the trust of those beneficiaries as well as that community.

Mrs. DAVIS. All right. Thank you. My time is up, so maybe we will get back later.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. Actually, I want to give you a little more time to unpack that, because I think that is an interesting idea. And I agree with you, but there is a sort of unspoken side to what you just said about beefing up these facilities, these major care facilities, and getting all these disciplines there, recapturing care. And the other side is the many, many other facilities in the MHS that are not of that size.

And so what do you think has to happen to those? Do they have enough critical mass, in your view, to provide value? Or is there a different model that should be used in those non-concentrated areas?

Colonel HEIMALL. Sir, I think we are already doing that. I know the Army has gone through this recently, at looking at a number of their smaller facilities. The MHS modernization report, which I don't think any of us has seen, is still working through staffing in the Department and is coming to you for review shortly.

I think it really becomes location-dependent. Colonel Place and I both served at Fort Campbell, Kentucky. I think we would have the opportunity and the density to be able to do that at a place like Fort Campbell. I think Lejeune is probably a similar size, and so I will allow Rick to tell you whether or not he could do that in his facility.

But I think there is a density and a size, and we have to be able to look at that from a, first, is it sustaining the readiness capability that we need at that location and with those deployable forces, and then does it make good business sense for us to be able to provide that there.

Mr. MACARTHUR. While you are talking, I want to follow up on my prior question from the last round. And I heard different perspectives from all four of you on how important it is for individual facilities to be within a specific branch of the Defense Department. You suggested that it is difficult because, if you are in one branch

or not, you are in a place where you have to do a lot of collaborating with others, and you have to focus heavily on the softer side of management, the relationship building, the managing up and down and sideways, to get things done that you may lack specific authority to get done.

What qualities, what management qualities, would we need in commanders of facilities that we are not—if they were moved—and I am not implying we will, but if they were moved to a combined medical command as opposed to being aligned within each service, what qualities would you need in commanders that have to navigate that world?

Colonel HEIMALL. Sir, I think you need the same skill set. The premium placed on my soft skills, my negotiating skills, consensus skills, that I have to use every day at Walter Reed are really not much different at all than what I had to do at William Beaumont or that I had to do at a much smaller MTF at Fort Riley, Kansas, as the commander.

I think when you have reached the colonel-level command and really some of the lieutenant colonel commands, you have got to have those soft skills to be able to get done what you need to get done.

Mr. MACARTHUR. Okay.

Switching to recapturing patients, particularly at some of the facilities where there is enough critical mass to do it, are there any specific—and I will look to others of you now—are there specific incentives that we could offer that might encourage people to access the MTF instead of private-sector care?

Captain FREEDMAN. Congressman, I think we are doing a lot of those right now. And it may even be on the softer side, of incentivizing. With the patient-centered medical home and putting the patient in the center of the care, really partnering with them and, as my colleagues were talking about, having them being part of our mission, we have really brought people back to our institutions, probably each one of us, in unprecedented numbers. We have had a 30 percent increase in enrollment at Lejeune. We have doubled the size of our retiree beneficiaries, which has helped with acuity in our cases.

So I think really partnering with them and really discussing the benefits of not a fee-based system and doing health care, not just leaving with a prescription. There are often questions about why don't we have a big billboard that says, "Four-minute wait in the ER." Now, that is because our ER physicians are phenomenal and our ED [emergency department] is great, but that is not patient-centered—

Mr. MACARTHUR. Could I ask you to follow up and show the statistics that you are alluding to and then some of the things you have done that you believe have caused that recapture. Because that is at the heart of one of the things we are looking at.

I yield back.

Captain FREEDMAN. We would happy to share that, Congressman.

[The information referred to can be found in the Appendix on page 83.]

Mr. MACARTHUR. Thank you.

Dr. HECK. Mr. O'Rourke.

Mr. O'ROURKE. Thank you.

I wanted to start this second round by just thanking Colonel Place for your description of what you do, why you do it, and who you do it for. When you finished, I wanted to work for you. And I feel like we should approach recruitment for these hard-to-recruit specialties—DOD, VA—with that spirit of service and this really unique, extraordinary opportunity you have to do something, you know, profoundly important for people who are doing really important things for this country. And so, anyhow, I thought that was great.

I wanted to continue with the question I asked and would allow anyone who would like to answer it to do so. If a service member prior to separation is seeing a therapist every 2 weeks for his or her PTSD, is it possible to continue that regimen once they separate? Is that already happening, perhaps? If not, could it?

And then the second scenario is a veteran who is diagnosed with PTSD after their service and is having a hard time gaining an appointment at the VA or a community provider. What is the opportunity to be seen at an Army medical or a military treatment facility?

And so I will begin with Colonel Heimall, since you were starting to answer that, and then anyone else.

Colonel HEIMALL. Sir, yeah, I was going to say, you know, I am very proud of what we were able to do for our Active Duty service members at Fort Bliss, from a behavioral health perspective. And we had some phenomenal success. We fell well short in what we were able to do for our family members and for our retirees, and we had to lean very heavily on the civilian community to be able to do that. And so what you saw from the Active Duty side was not what we were able to provide for everyone else.

I think we would like to get to a system where we could have that continuity. I think the challenge becomes, does the veteran stay in the community where they were receiving care when they were on Active Duty? Increasingly, in your district, that is happening, but in a lot of districts, there is an out migration, as well, and so sustaining the continuity becomes a problem.

Certainly if we had sufficient capacity at Walter Reed for Active Duty family members, retirees, and veterans, we would be reaching out to the VISN [veterans integrated service network] five facilities and making sure that we were using that capability well.

Mr. O'ROURKE. Anyone else?

Colonel PLACE. Absolutely. So, sir, you are welcome to join anytime. We will send you an application.

So this is a real problem for mental health in particular. I have talked to our public health department in Pierce County, and one of the concerns that they have is they have one of the lowest per capita behavioral health; psychiatrists, psychologists, inpatient beds, and so forth. They are trying to fix that. And it is at the same time that I am opening a residential treatment facility for substance abuse within Madigan. So we are literally trying to get the same people to come to work. And so I am a little concerned, and I have expressed that concern, that we are in this competition together.

Mr. O'ROURKE. How about that specific scenario of a service member being treated, they separate, they are still in the community; could they go back and see the same, very same psychologist that they saw at your military treatment facility?

Colonel PLACE. So I can't answer you right here, sir. I would check with our managed care folks. And then probably I think the way that I would have to approach that is see whether or not we could do secretarial designee for them in order to get them in for a short period of time until whatever the crisis was—

Mr. O'ROURKE. In other words, it is not a standard operation procedure. It would—

Colonel PLACE. No, sir.

Mr. O'ROURKE [continuing]. Be an exception.

Colonel PLACE. It would all be an exception of policy for all of those.

Mr. O'ROURKE. Yeah. And I guess my thought is, you know, just using the El Paso anecdote again, if the service members with whom I have spoken about this say, "While I was at Fort Bliss, I got excellent behavioral health care; if I was supposed to see someone every 2 weeks, I saw them every 2 weeks; when I transitioned to the VA, I did not," if you are able to serve, you know, 100 percent of the need in the Active military and some percentage far short of that in the VA, could you expand, stretch your capacity a little bit to ensure that people are receiving their treatment? Or am I hearing you all say that you are at capacity, you cannot spare additional hours?

Captain FREEDMAN. Congressman, I think that we talk about relationships, and certainly I am proud of the relationships that we have established with the VA in our local area. We are partnered with the VA Medical Center in Fayetteville and the VA Center in Wilmington.

We have actually embedded a community-based outpatient clinic in one of our branch health clinics aboard Marine Corps Base Camp Lejeune and started a pilot project at our Wounded Warrior Battalion, where we have our most vulnerable marines who are transitioning out of the service, and doing a warm handoff right to our branch health clinic to see a VA team so we don't lose them in the system, they can have some continuity. And I think that that is going to pay great dividends in the future.

Mr. O'ROURKE. Thank you.

I am out of time. I will yield back to the chair.

Dr. HECK. Well, with the panel's indulgence, we will do something that we haven't done before, at least in my tenure as chair, and that is move to a third round of questions.

Colonel Heimall, I am really intrigued about the command structure at Wally World [Walter Reed] right now. So you have a director with no command authority, as I understand it, over the personnel within the facility. So who actually does exert command authority over those individuals? And how is that a benefit or a hindrance to the overall operation of the facility?

Colonel HEIMALL. Sir, I think, first of all, it is important to understand, and to put it into Army terms, the director exercises mission control for the healthcare delivery mission at Walter Reed-Bethesda.

We have a very large Army detachment and a very large Navy detachment. The special court-martial convening authority that I would have normally had as an Army commander, that Colonel Place has, resides with an Army troop commander who sits on Bethesda. I see him several times a day normally, and we talk closely, particularly on senior NCO [noncommissioned officer] and officer issues. And General Becker, the Military District of Washington commander, holds the general court-martial convening authority.

Same thing for the Navy, though now with Rear Admiral Lane as the director, Navy Bureau of Medicine and Surgery has delegated UCMJ [Uniformed Code of Military Justice] authority for the Navy detachment at Walter Reed and Fort Belvoir to Admiral Lane. And so he is able to exercise that for the Navy detachment.

Our small Air Force detachment, the authorities are over at Malcolm Grow.

That really is no different than what my experience was as an Army MTF commander, where I had a medical chain that really had no general court-martial convening authority over my soldiers at Fort Bliss. That went through the Fort Bliss commander.

And so you are constantly building a relationship with your senior commander on your installation and with your higher headquarters to coordinate—you know, is every privileging action on a physician an officer misconduct issue? It is not. And so it doesn't need to be in the UCMJ chain. And how do you build that understanding? It is through building the relationship with your senior commander and with your medical chain of command.

Dr. HECK. Okay. Thank you. That is very helpful.

You know, one of the other issues that we have discussed—again, you know, the whole purpose behind this and this series of hearings is in preparation for the MHS study and what does MHS look like in the future. And that is why we thought it was critically important to talk to the MTF commanders that are really the foundation upon which MHS is built.

If you can, just talk a little bit about your staffing models and how you figure out how many bodies you need in your facility in uniform of given specialties. I would imagine it is based on your go-to-war mission and what you are going to need to send forward should the balloon go up.

And how do you balance that with then meeting the needs of beneficiaries, you know, when you look at a specific model of having so many in-uniform providers? And your feelings on the substitutions of, well, you know, an OB/GYN [obstetrician/gynecologist] can be .5 general surgeon if we move forward, and is that the right way to staff for military contingencies.

I am going to start with Colonel Littlefield, if I could.

Colonel LITTLEFIELD. Certainly. Yes, sir.

Again, I come back to the word "balance." It is something we try to look at for the Air Force when we POM [program objective memorandum] out or look ahead, years ahead. We try to determine what that is going to be and have that ability to provide the care to our members.

But it does start with what our wartime mission is. You know, at the end of the day, there is no separation. We are constantly keeping people ready; doesn't matter if it is wartime or not. But if

our people are deploying, we have to have those people ready to go at a moment's notice and still take care of the people back home, as well.

So I would just say projected out as much as we can, discussions with our headquarters, and talking through the benefits that we need to provide our community.

Dr. HECK. So would you say that, you know, you have a certain number of uniformed healthcare providers based on your wartime mission, and then do you beef that up based on your beneficiary population is? Or do you just look to then get in civilian providers to take care of the delta?

Captain Freedman.

Captain FREEDMAN. Mr. Chairman, much like Colonel Littlefield, our OPLANs [operational plans] determine a bit of our manning there, with the combatant commanders feeding that information. And it is put through what we call MedMACRE, which is Medical Manpower All Corps Requirements Estimator. And in that, we build a seashore rotation base, a platform for our service men and women to rotate overseas, those forward contingencies. And then we have the beneficiary mission and the training mission all built into that too.

To get to your question on can we flex to meet the needs in the local community, absolutely. We have a great mix of Active Duty, as we have talked about from that estimate, but also GS [general schedule] and contract staff members, all playing an integral role. We have our GSes, our continuity to make sure that when we PCS and transition there is someone to provide that continuity of leadership and training for the staff. The contract force can be brought in easily to meet mission requirements from our commanders on the base or from working with our managed care support contractor in trying to recapture care.

So we have that base from the OPLANs, and then we have some flexibility on the ground as a commander.

Dr. HECK. Either of the other—anything different from either of you in that regard?

Colonel PLACE. It is remarkably similar. Once we get through Total Army Analysis based on the COCOM [combatant command] requirements, we go through a human capital distribution program that then allocates out the uniformed members. And then, after that, we preferentially go to GS. And then, when we need to, based on, you know, time, how long you need to have it, how quickly, and so forth. So we do the analysis based on that to follow it up.

Colonel HEIMALL. Sir, I think the challenge we have at Walter Reed, as I have learned over the last 5 months, is we are dealing with three different staffing models. And we somehow—everybody thinks theirs is perfect. I think there are some really great things about each of the services' staffing validation models.

The challenge is—and DHA has been very, very supportive in helping us work through this—is how do we find the right one to support what we are doing and demonstrate to the services that their military staff assigned to us are really getting the competencies and skills sustainment that they need when they go back out to a smaller service platform or when they deploy with their service.

Dr. HECK. Great. Thank you.

Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

And perhaps I will give Captain Freedman and Colonel Littlefield, if you have something you would like to add to the discussion of: What should change? What would you like to see?

Captain FREEDMAN. Thank you, Ranking Member Davis. When you had asked that question, I had hoped to get to answer it. Because when we talk about change, I am truly excited to be living that change right now, as we look at changing from providing health care to health and bringing patients involved in making decisions. When we are looking at outcomes, we are not looking at productivity models but really getting our populations healthier, which, in the long run, is going to provide a cost-benefit and it is going to be a more able fighting force.

It is truly an exciting time in medicine but particularly in military medicine and MHS as we lead the charge on some of these initiatives.

Mrs. DAVIS. Thank you.

Colonel.

Colonel LITTLEFIELD. Ma'am, I would concur. I would say the focus on prevention, as opposed to taking care of it after the fact, an injury or medical condition; educating the patients on the importance of that, and not just the Active Duty members but the families, the retirees, and just placing the importance on how much more you can save doing that. And the access to care can become an important factor in that, as well, too, when you may not have to rush in to get an appointment if you are taking care.

So I would just say the education on prevention.

Mrs. DAVIS. Great. Thank you. I appreciate that. And we are seeing a lot of those changes.

Just very quickly, one of the concerns that was expressed here at one point was, shouldn't we have fewer OB/GYNs and more trauma surgeons? You all mentioned—I think most of you mentioned in your remarks that, you know, obviously, that preponderance of physicians are really helping to deliver babies, which is a good thing. But what do you say to people when they say, shouldn't they be doing that in the community?

Colonel PLACE. Well, I would frame it a little bit differently, ma'am, if I could. I think we have to make sure that we have a broad perspective. You know, we have to respond to all things. So Ebola, a great example. We have professionals whose full-time job is to look at those kinds of tropical and emerging diseases and so forth. We have folks that specialize in disaster management. So there are a lot of other things that, frankly, the Nation is going to ask us to do, and we have to be prepared to do that.

So I always become concerned when we talk about trauma management, and that is the coin of the realm for what we talk about, when most of the care that gets provided in theater is not. I am a family physician, so most of what gets done is what I do. And every now and then, we go do some trauma too.

Being a combat support hospital commander in Helmand province with our British colleagues at Camp Bastion and so forth, I understand trauma and I understand how important it is to do

that well. But there are a lot of other things that we have to be very good at.

So I would just urge caution if we say that the thing that is important is trauma, because that is going to leave us a shortfall in a lot of other things.

Colonel HEIMALL. And, ma'am, I think that is one of the things that really makes military medicine unique compared to a civilian healthcare system. Increasingly, as Ms. Tsongas pointed out, larger numbers of women serving in our force. One of the things that we are seeing is an increase in the number of new cancer diagnoses among our forces every year. A portion of those are gynecological cancers. It gives us an opportunity to be able to manage that from a readiness perspective with those providers and our force.

As Colonel Place said, he is a family physician. Oftentimes, the first physician that a wounded soldier or sailor or service member sees on the battlefield is going to be a pediatrician or a family physician or a cardiologist who is in a battalion aid station.

We ask those providers to go through advanced trauma life support and tactical combat casualty care, and then we ask them to actually execute that on the battlefield. Our civilian counterparts do not do that with their pediatricians and their cardiologists and their internists.

Mrs. DAVIS. Right. Yeah.

Captain FREEDMAN. And I would like to point out that taking care of families impacts readiness. It is not just a benefit. This truly impacts the readiness of our Nation. I bring our commanding generals from Marine Corps Base Camp Lejeune to our centering room for pregnancy so he can see what happens to the family members, because that is truly a concern of his because he knows that impacts readiness. So I think that that is important.

And the other piece that we do incredibly well in military medicine is as providers to give disposition to the line commanders. That doesn't happen in the civilian communities. You can get a diagnosis, but a disposition—does this marine or sailor or soldier, airman, do they need to be on light duty? Can they carry a weapon? Can they do their mission? You can't learn that overnight. That has to be brought up in the system. So I think we are very proud to be able to do that.

Mrs. DAVIS. Thank you.

Thank you all.

Thank you, Mr. Chairman.

Dr. HECK. Thanks.

All right. I have one last question.

Captain Freedman, you talked about some of your innovative access programs, whether it is using a smartphone or your advice line. Is that a best practice through BUMED [Bureau of Medicine and Surgery], or is that something you are just doing at your facility?

Captain FREEDMAN. Thank you, Chairman.

It is actually brought by Navy Medicine to innovate—and that is what is great about our system—through our regional commands to share best practices with each other. So we are not the only MTF to have a smartphone application. We have an incredible

number of downloads, over 6,000 right now, and patients are actually using them.

So we learn from each other, but it is not—even though we developed it at Camp Lejeune, it is something that we share throughout the services.

Dr. HECK. So it populates amongst the tri-service community, not just within Navy Medicine.

Captain FREEDMAN. Well, the innovation, I mean, it is an individual application for our facility. But the concept is something that we share throughout Navy Medicine. And I think it is going to really, I mean, I am sure, as you are aware, will change the way that we deliver medicine in 5 or 10 years from now.

Dr. HECK. Yeah.

Colonel PLACE, you got something you want to add there?

Colonel PLACE. Yes, sir. I would add I know of at least two Army facilities doing the same thing, that have created similar apps. And we have talked; as commanders, we get together and have opportunities to discuss.

So, yes, I think we do a pretty good job overall within the services of innovating, to try and keep up with what the expectations are from our beneficiaries. I think that is important that we do that and they become best practices and then we disseminate them out. So that whole knowledge management piece is important, I think, within the services, and I think we are doing much better at that.

Dr. HECK. Great.

Well, again, I want to thank all of you, the four of you, for taking the time and hanging here in this very hot room for an hour and a half and through three rounds of questions.

I found the information very insightful and helpful as we try to tackle the MHS reform study, when and if we get it, but certainly in looking forward of how we make the military healthcare system meet its vision of having a dual readiness mission of making sure we have ready healthcare professionals to deploy and we keep our force ready to deploy.

So, again, thank you all very much.

And, Mrs. Davis, thanks for staying so long. I know it has been a long one.

And we will be adjourned.

[Whereupon, at 3:37 p.m., the subcommittee was adjourned.]

A P P E N D I X

FEBRUARY 3, 2016

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

FEBRUARY 3, 2016

Opening Remarks – Chairman Heck
Military Personnel Subcommittee Hearing
Military Treatment Facilities
February 3, 2016

Good afternoon.

Today the Subcommittee meets to hear testimony on military treatment facilities, or MTFs, which are the medical centers, hospitals, and clinics that are owned and operated by the Department of Defense and the military services.

For decades, military treatment facilities have been recognized as the foundation of military medical care. They are the primary location for active duty military to receive treatment and are the training and education platforms for medical providers worldwide. Every member of the military health care team, me included, has spent time in MTFs. If you have served in the military, chances are you have received care in an MTF for everything from immunizations, to routine health screenings prior to deploying to witnessing the birth of your children. Depending on the size and location, MTFs provide a wide range of medical services to active duty, active duty family members, retirees and retiree family members.

However, military health care, alongside civilian health care, has evolved and we have seen many changes to MTFs. The certainty that a military installation will have a full service medical facility is a thing of the past. For example, in 1989 there were more than 500 military medical facilities worldwide—168 military hospitals and hundreds of clinics. Today, there are 55 hospitals and 360 clinics for a total of 415 MTFs. Large medical centers, such as Fitzsimons Army Medical Center, once considered an enduring capability have closed.

The reasons for some of these changes are varied. Health care has largely shifted from being inpatient focused to outpatient settings such as ambulatory surgery and care models such as patient centered medical homes. Another reason, unique to military medicine, realignment of troop units and closure of military installations has shifted the need for medical care to follow suit.

So the question we now ask is what is the future of military treatment facilities? How do they maintain the primary mission of readiness of the force and ready medical professionals? Are MTFs currently situated to support the readiness mission along with the mission to provide care to their beneficiaries?

I am interested to hear from our witnesses about the challenges of running an MTF. How are MTFs different than civilian medical facilities? How does MTF leadership balance readiness requirements and the needs of the beneficiary population, including service members, family members and retirees? And finally, what can we do to ensure

the military health system has trained and ready providers to support the readiness of the force and provide a valued health benefit to our beneficiaries?

With that, I want to welcome our witnesses and I look forward to their testimony. Before I introduce our panel, let me offer Congresswoman Susan Davis from San Diego an opportunity to make her opening remarks.

**STATEMENT BY
COLONEL MICHAEL S. HEIMALL, U.S. ARMY
CHIEF OF STAFF
WALTER REED NATIONAL MILITARY MEDICAL CENTER**

BEFORE THE

**HOUSE ARMED SERVICES COMMITTEE
MILITARY PERSONNEL SUBCOMMITTEE**

SECOND SESSION, 114TH CONGRESS

ON MISSION OF MILITARY MEDICAL TREATMENT FACILITIES

**NOT FOR PUBLICATION UNTIL RELEASED BY THE
HOUSE COMMITTEE ON APPROPRIATIONS**

Chairman Heck, Ranking Member Davis, and distinguished members of the committee, thank you for the opportunity to discuss what we at the Walter Reed National Military Medical Center (WRNMMC) do to ensure sustainment of the trauma, critical care, and rehabilitation capabilities developed over the past 14 years, while maintaining the commitment of timely access to the best healthcare our Nation offers to our service members, retirees, their families and eligible veterans.

I am the current Chief of Staff at WRNMMC and, until this past Monday, I also served as the Interim Director. Our joint team, composed of Army, Navy, Air Force, Public Health Service, civilian and contractor healthcare professionals, is committed to providing an extraordinary patient experience, and ensuring that our staff are ready to support our combatant commanders anywhere and anytime.

Walter Reed is unique within the Military Health System. It is where our Nation heals its heroes. While the medical evacuation rate from theaters around the world to Walter Reed is currently equivalent to that experienced from 2001-2003, prior to Operation Iraqi Freedom, the number of wounded, ill, and injured service members on our campus has remained steady for the past 3 years. Two years ago, 68% of these patients had combat related injuries compared to 42% today. Because of our recognized expertise in a number of areas, we are seeing increasing numbers of service members with cancer, injuries from motor vehicle and motorcycle accidents, and traumatic brain injury from training accidents. This allows us to apply what we have learned from these last 14 years of combat and to improve treatment with ongoing innovative approaches.

Like the other facilities represented here today, Walter Reed's first mission is to ensure our providers, nurses, allied health professionals, medics and corpsmen are trained and ready to provide world-class healthcare to Soldiers, Sailors, Marines, and Airmen on the battlefield or in garrison. Our military medical staff deploy around the world in support of a wide-variety of contingency missions – from combat missions in Afghanistan to Ebola relief in West Africa to Global Health Engagement aboard the USNS Comfort. In these environments, they use the experience and skills they have perfected caring for service members, families, retirees, and veterans back in Bethesda.

Maintaining a ready medical force requires a system of care that allows the entire team – physicians, nursing, anesthesia, respiratory therapy, laboratory, and radiology – to exercise skills in caring for critically ill and injured patients. While there is no substitute for the extreme, penetrating trauma seen in combat, treating critically ill patients with time-sensitive diagnoses such as stroke, heart attacks, and motor vehicle accidents allows the entire care team to hone their skills.

Within the National Capital Region Medical Directorate, we believe we owe the Army, Navy, and Air Force trained and proficient medical professionals who leave us better prepared for their next assignment. Accordingly, we are working with the Services, Uniformed Services University of Health Services (USUHS), and professional societies like the American College of Surgeons to develop core competencies required for our entire healthcare teams. The Air Force has recognized the skill development and sustainment value by committing more than 40 critical care nurses to staff our Intensive Care Units. These nurses develop and advance the skills they need to care for patients as members of Critical Care Aeromedical Evacuation Teams.

In addition, our educational mission is another important aspect of what we do at Walter Reed to grow the military medical team of the future. Walter Reed and the National Capital Consortium operate more than 68 training programs with over 700 students across the National Capitol Region. Nearly one-third of physicians in the Military Health System train at Walter Reed. The core strength of these training programs is the experience of the faculty and the diverse, complex patient base provided by our families, retirees, and veterans. Further enhancing our training experience is the strong partnership we have with the USUHS, the National Cancer Institute (NCI) and the National Institutes of Health (NIH) which I will discuss later in this statement. The outcome of these educational efforts is reflected in the overall first-time board certification pass rate of 95% for our residency program graduates compared to 87% nationally.

PARTNERSHIPS TO ENHANCE READINESS

Walter Reed is truly a national asset and home to several centers that are recognized nationally and internationally for their innovations and advances in their field. The Military Advanced Training Center (MATC) is our Nation's premier rehabilitation center for amputees. The MATC continues to advance the development of prosthetics and rehabilitation techniques by treating patients wounded in combat, stricken with cancer, injured in accidents, and even victims of the Boston Marathon bombing. We share the advances and improvements collaboratively with the Center for the Intrepid in San Antonio along with NIH, VA, and industry.

The John P. Murtha Cancer Center continues to enhance its national reputation through an innovative partnership – the Tri-Federal Cancer Initiative – with the NCI and

USUHS. This initiative allows Walter Reed and the NCI to exchange patients to provide care not available at the treating hospital. As part of this initiative, the Secretary of Defense has delegated Secretarial Designee authority for up to 100 NCI patients a year to the Walter Reed Commander.

The first patient to benefit from this partnership was a 17-year old who had a hip disarticulation to treat his bone cancer. That patient received his rehabilitative care at the MATC. Another patient was a 16-year old girl at risk of losing her eyesight from a tumor. Walter Reed surgeons performed sight-saving surgery and returned the patient to NCI for her cancer care. Our patients also benefit from this partnership, for example they can more easily access the clinical trials conducted at NIH. Recently, an Active Duty patient was diagnosed with a rare blood cancer at Walter Reed. Within 24 hours of diagnosis, the patient was moved to NIH and enrolled in the only clinical trial in the country for his type of cancer.

Last year, the National Intrepid Center of Excellence (NICoE) was integrated into Walter Reed. This allowed us to integrate three separate TBI-related programs, as well as our research and treatment programs while continuing to partner with the NICoE satellites located at selected military treatment facilities around the country. In addition, Walter Reed created an inpatient treatment unit for patients with moderate to severe TBI. These patients are either too severely injured to benefit from the NICoE's outpatient programs or have not responded to intensive outpatient care. Initially opened as a 6-bed unit, we will expand this capability to 10 beds this year.

Over the past 18 months, we have reached out to the Department of Veterans Affairs to improve access to care for our veterans across the National Capitol Region

and across the country. Since 2012, we have more than doubled the number of veterans admitted to our inpatient wards and increased outpatient encounters by 272%. Our vascular surgeons travel to the Martinsburg's VA hospital to operate and the Baltimore VA increasingly refers patients to our Transplant service. Our veterans are some of the most complex patients we care for and often require the same critical care as wounded service members evacuated from the battlefield.

In November, Walter Reed became the first federal facility on the East coast to performing transcatheter aortic valve replacements. This procedure is reserved for the sickest of patients who are not candidates for a traditional, open heart procedure. These complex patients are another example of how we can expand our critical care services to sustain our skills while implementing life-saving procedures for patients who would otherwise have little hope of surviving their disease or injury.

Lastly, the Ebola outbreak in West Africa last year expanded our relationship with NIH. As a result of this outbreak, WRNMMC maintains an Enhanced Precautions Unit as a DOD infectious disease asset creating expansion capability for beneficiaries in case of an Ebola or other infectious disease outbreak in the United States. We patterned our unit, equipment, and procedures after those used at the NIH Clinical Center. We have continued to expand our relationship with NIH in this area to facilitate the sharing of staff, if necessary, in a future crisis.

IMPROVING THE PATIENT EXPERIENCE

Walter Reed is the tertiary care medical center within the National Capital Region Medical Directorate (NCRMD). Unlike the other enhanced multi-service markets, the NCRMD is subordinate to the Defense Health Agency, which exercises operational

control of both WRNMMC and the Fort Belvoir Community Hospital. Within the NCR market, we are improving the patient experience by increasing services, moving care closer to the patient, and more efficiently managing shared functions like appointing and referral management. In particular, we make specialty care more convenient and accessible for the patients in the NCRMD. For example, WRNMMC specialty providers routinely see patients and operate in the NCR's smaller facilities. We have placed full-time providers in gastroenterology and podiatry at Ft Meade, MD, and Ft Belvoir, VA. We have hired 11 physical therapists to improve access to those services across the region. Today, we defend staffing not by the workload performed at the Bethesda campus, but based on what the region requires.

We are consolidating appointing and referral management functions for the entire market at one Referral Management and Appointing Center. By the end of FY16, all patients will be able to call one number in the NCRMD for appointments at any facility. And no patient will experience delays in care waiting for an overworked physician to review a specialty consult. Using a trained team of nurses with referral guidelines, we are centrally reviewing consults for care and proactively appointing the patient. The key to these improvements is strong leadership in each of our product lines and a central focus on putting the patient at the center of all we do.

DEVELOPING AN ACADEMIC HEALTH SYSTEM

An emerging model in academic medicine today is the Academic Health System (AHS). An AHS is an integrated delivery system with a broad regional presence and clinical services that are aligned across the continuum of care. An AHS generally includes an integrated delivery system, a medical school, and at least one other health

professions school with a mission to improve the health and well-being in their communities by: (1) educating and training the next generation of health professionals; (2) conducting biomedical, translational, and clinical research; and (3) providing the highest quality comprehensive primary and advanced specialty care. Examples of such systems are Emory Healthcare, UCLA Health, University of Pittsburgh Medical Center, and Vanderbilt University Medical Center.

WRNMMC and USU are working together to create our own unique equivalent of an AHS that will ensure an extraordinary patient experience and a superb academic experience for our residents, medical and nursing students. We are integrating the clinical and academic department chairs when it makes sense to provide unified leadership. The goals are to increase the clinical productivity of USU faculty, engage all WRNMMC staff in teaching of students, and create synergy and efficiencies within our research programs. For example, WRNMMC oncologists are leveraging USU's genetic sequence research program to sequence the genetic make-up of cancer tumors of our patients in the same manner commonly done at cancer centers like Sloan-Kettering or M.D. Anderson.

We are also expanding our AHS model to include our relationship with NIH for both research opportunities and additional training. The addition of the NIH will encourage faculty and staff from each entity to conduct joint research initiatives. For example, we have begun offering research grants for proposals with principle investigators from each entity. We have also published a consolidated list of research proposals under way at each institution. These actions expand collaborative research opportunities among all three institutions. Lastly, we routinely host NIH Fellows at

WRNMMC to further expand their educational opportunities and to expose our own students, residents and staff to new ideas and clinical collaborations.

All of these activities and relationships are designed to enhance the readiness of our military medical force while ensuring timely access to the best healthcare our Nation has to offer. Our military treatment facilities, like WRNMMC, generate the ready medical forces needed to continue the phenomenal success we have realized over the past 14 years at the point of injury, through improved care by medics and corpsmen to far forward surgical care, advanced critical care aeromedical evacuation, to our unique health campus where the most severely ill and injured come for definitive care and rehabilitation. We are a fully integrated system committed to continuously improving our system of care and meeting our military mission.

Thank you for the opportunity to speak with you today. I look forward to answering your questions.

Colonel Michael S. Heimall
Medical Corps, United States Army
Chief of Staff, Walter Reed National Military Medical Center

Colonel Michael S. Heimall is a native of Sussex, New Jersey. A Distinguished Military Graduate, Colonel Heimall earned his commission from Norwich University in 1987. Colonel Heimall holds a Bachelor of Arts Degree in International Studies from Norwich University, Northfield, Vermont; a Master's Degree in Healthcare Administration from Baylor University, Waco, Texas; and a Master's Degree in Strategic Studies from the US Army War College. He is a graduate of the US Army Command and General Staff College and the US Army War College.

He has held numerous positions during the past 28 years culminating in his current assignment as Chief of Staff, Walter Reed National Military Medical Center. COL Heimall's previous assignments include Assistant Chief of Staff, TRICARE Transition, Western Regional Medical Command, Joint Base Lewis-McChord, Washington. Deputy Commander for Administration, US Army Medical Department Activity & Blanchfield Army Community Hospital, Fort Campbell, Kentucky; Congressional Liaison, Office of The Surgeon General; Assistant Executive Officer to the Surgeon General and Commanding General, US Army Medical Command; Senior Health Policy Analyst, Office of The Surgeon General; Director of Business Operations for the North Atlantic Regional Medical Command, Walter Reed Army Medical Center; Chief of Managed Care and Resource Management, US Army Medical Department Activity, Fort Meade, Maryland; Chief of Managed Care and Clinical Support, US Army Medical Department Activity, West Point, New York; Executive Officer, US Army Dental Activity, Fort Leonard Wood, Missouri; Administrator, Department of Radiology, Dwight D. Eisenhower Army Medical Center, Fort Gordon, Georgia; Aide de Camp to the Commanding General, Dwight D. Eisenhower Army Medical Center; and Executive Officer, Headquarters & Headquarters Company, 18th Medical Command and 121st Evacuation Hospital, Seoul, Korea.

Colonel Heimall's command experience includes serving as the Commnader, William Beaumont Army Medical Center, Fort Bliss, Texas; Commander, US Army Medical Department Activity & Irwin Army Community Hospital, Fort Riley, Kansas; Medical Company Commander, 93rd Evacuation Hospital and the Detachment Commander, US Army Dental Activity, Fort Leonard Wood, Missouri. He deployed as the Medical Operations Officer for the Combined Forces Special Operations Command Central. His awards and decorations include the Legion of Merit (2OLC), the Meritorious Service Medal (3OLC), the Joint Service Commendation Medal, the Army Commendation Medal (1OLC), the Army Achievement Medal (1OLC), the Armed Forces Reserve Medal, and the Army Staff Identification Badge. Colonel Heimall is a member of the Order of Military Medical Merit and is a Fellow of the American College of Healthcare Executives. COL Heimall also serves as the Army Surgeon General's Consultant for Healthcare Administration.

He is married to the former Lynda Mullen of Littleton, Massachusetts. They have three grown children, Christian, Brandon, and Michael.

RECORD VERSION

STATEMENT BY

**COL MICHAEL L. PLACE
COMMANDER, MADIGAN ARMY MEDICAL CENTER**

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

SECOND SESSION, 114TH CONGRESS

ON MILITARY TREATMENT FACILITIES

3 FEBRUARY 2016

**NOT FOR PUBLICATION UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE**

Chairman Heck, Ranking Member Davis, and distinguished members of the subcommittee, thank you for the opportunity to represent Madigan Army Medical Center and Army Medicine today. As a large medical center located on Joint Base Lewis-McChord, Madigan is a network of Army health readiness platforms located in Washington and California. Much like civilian academic medical centers, Madigan provides a wide array of medical services, such as patient-centered adult and pediatric primary care, general medical and surgical care, a 24-hour emergency room, specialty and sub-specialty care, behavioral health and wellness services. Additionally, we perform the services typically associated with the local department of health and a variety of preventive medicine and occupational health services to several small installations in the region. Madigan is a regional referral center for specialty care in our enhanced multi-service market, the Puget Sound Military Health System (PSMHS), providing patient centered care to ensure medically ready forces and ready medical forces for a premiere power projection platform in support of I Corps.

Since 1944, Madigan has been a provider of world-class patient care, an unparalleled education facility and state-of-the-art research platform, practicing readiness and deployment medicine while engaging as a committed community partner. Team Madigan's mission "proudly promotes the health and wellness of America's Military Family" with our vision of "being patient-centered in all we do." Madigan cares for over 100,000 beneficiaries with around 5,000 staff members and supports over 250,000 eligible beneficiaries as the tertiary referral facility for the PSMHS. Madigan also boasts a robust internal American Red Cross program with approximately 200 volunteers who donate thousands of hours of service monthly.

As Army Medicine's second largest military treatment facility and one of the most state-of-the-art and technically advanced medical centers, Madigan is one of only two designated Level 2 trauma centers throughout the U.S. Army Medical Command (MEDCOM). Madigan trained 319 individuals in Graduate Medical Education in 33 distinct training programs in 2015. An affiliated institution with both the Uniformed Services University of the Health Sciences and the University of Washington, Madigan provided clinical rotations for 617 medical students and volunteers in 2014.

Madigan's Andersen Simulation Center (ASC) staff provided state of the art simulation training to 7,495 doctors, nurses and medics during academic year 2015. The ASC is one of only 7 simulation centers in the U.S. to achieve Level 1 Accreditation by the Society for Simulation in Healthcare, and one of 82 surgical simulation centers in the U.S. to achieve a Level 1 Accreditation from the American College of Surgeons. Level 1 dual accreditation is held at only a handful of centers in the U.S. Additionally, the ASC is a Defense Health Agency TeamSTEPPs Center of Excellence.

For eight of the last nine years, Madigan was named among the "100 Most-Wired Hospitals and Health Systems" by The Most Wired Survey and Benchmarking Study, conducted annually by Hospitals and Health Networks. Madigan has a data sharing agreement in place with the VA's VISN 20 allowing clinical staff for both facilities to log onto the other's clinical information systems. We also serve as the primary test site for all DoD/VA data sharing. Madigan uses the Virtual Lifetime Electronic Record (VLER), which permits our network partner, MultiCare Healthcare System to view data directly. Madigan is the only MTF in DoD with a fully functioning electronic Personal Health Record (PHR) for its beneficiaries. We are also the only DoD Health Readiness

Platform awarded the Top 25 Environmental Excellence Award in 2014 sponsored by Practice Greenhealth, the highest award level. Madigan leads JBLM in support of Net Zero Sustainability Goals for Water and Air Quality, Energy Conservation and Waste Reduction. Our hospital logistics team recently achieved the ISO9000 award status, the first in the Military Health System.

MEDICAL READINESS

Madigan has contributed to a fully medically ready rate of 85.7% and a deployable rate near 91% for Soldiers on JBLM, which well exceeds the Army average of 83.4%. These results came from a concerted effort over time along with our line commanders, unit medical providers and our dental colleagues. We review the data, modify policy and apply resources through a monthly Senior Medical Council to synchronize and prioritize our efforts. Importantly, the Army has resourced our line units with physical therapists and our Soldier Centered Medical Homes to review population health data in order to decrease injury rates, the number one reason Soldiers are not medically ready.

JBLM is a pilot site for Army Medicine's Performance Triad and we anticipate that the data will show how proper activity, nutrition and sleep can improve health and wellness in large formations. Under LTG Lanza's leadership, we are working with senior installation leaders to devise new initiatives to further improve JBLM's readiness posture.

READY MEDICAL FORCES

Madigan residency programs boast a 95% 3 year first time board pass rate, 94% for AY 14-15 exceeding the 87% national average. The Orthopedics, Neurology, and Radiology programs' in-service examination performance this year places them in the top 10% of the nation and our Emergency Medicine Residency remains one of the top in the country. Our graduates are prepared through a military unique curriculum to transition into unit surgeons in maneuver units or serve in Forward Surgical Teams (FSTs) or Combat Support Hospitals (CSHs). As a former CSH Commander who served in Afghanistan, I have witnessed first-hand how our GME and related medical training programs provided the capability to achieve our unprecedented 92% survival rate despite the increasingly dire injury severity rates suffered by our patients.

Madigan's Charles A. Andersen Simulation Center, home to the Army's Central Simulation Committee, expanded to create a Just-in-Time Simulation Area (JITSA) in the main hospital in 2012 and has already trained more than 3,000 individuals. Much like a pre-flight simulator for our aviation colleagues, the JITSA provides clinicians the opportunity to rehearse prior to encountering live tissue.

The ASC is a Fundamentals of Laparoscopic Surgery Training and Testing Center, the only testing center for the State of Washington and has submitted a request to become a Fundamentals of Endoscopic Surgery Training and Testing Center. The ASC continues to support and coordinate the Advanced Trauma Operative Management (ATOM) and Advanced Surgical Skills for Exposure in Trauma (ASSET)

Courses in conjunction with multiple FSTs and the 47th CSH often felt by deployed surgeons to be the most valuable pre-deployment training they received.

The Andersen Simulation Center created novel Ebola training by incorporating skill training while in personal protective equipment during treatment scenarios. The scenarios required learners to conduct assessments and interventions for the care of a deteriorating patient, a mannequin capable of transferring contaminated secretions to staff via an aerosolized fluorescent material thereby providing direct, non-lethal feedback to the care provider.

Our facility remains a long-term partner with our local civilian colleagues as an American College of Surgeons Level II trauma center, participating in the Tacoma Trauma Trust. We average over 1 trauma code activation daily to support our community and provide ongoing trauma training for our staff.

Madigan remains globally engaged with approximately 20 staff members deployed worldwide and dozens more preparing or on standby for other missions. Our GME programs provide academic rigor and ensure our medical teams are trained, ready and relevant to provide care globally.

CARE WITH COMPASSION

Madigan is dedicated to providing top quality, safe and accessible patient-centered care for all of our beneficiaries. The MHS Review gave us the opportunity to look at ourselves more closely and I am pleased to report that we have made great strides to meet benchmarks and increase compliance with 15 of the 22 National Surgical Quality Improvement Program (NSQIP), National Perinatal Information Center

(NPIC) and The Joint Commission ORYX measures evaluated in the Review in a little over one year. We anticipate continued improvement in the near future as the data collection catches up to our current performance.

Of the 10 Healthcare Effectiveness Data and Information Set (HEDIS) scores we monitor closely for out-patient quality in the Military Health System, Madigan exceeds the 90th percentile in 4, is over the 75th percentile in 2 others, over the 50th percentile in 2 more and nears the 50th percentile in the final two.

Madigan's access to care remains strong, with our third next available acute appointment being available within 1.6 days. However, we improved this metric from November 2012 through December 2015. With our ongoing initiatives, we should meet the target of less than one day NLT FY 2017. Our internal data suggests that the actual time seen for all acute appointments is actually 0.6 days so that if you call today for an appointment, we generally see you today or provide a referral to the network.

Similarly, we are incorporating Army Secure Messaging System (Relay Health), our national Nurse Advice Line and maximizing the use of tele-health to improve our access. Madigan's School Based Clinics provides patient-centered primary care to TRICARE Prime adolescents at seven middle and high-schools in the local community, increasing access for this population while minimizing time away from school for the student and the time away from home or work for their parent(s). The program began in 2012 as a pilot through an American Academy of Pediatrics grant (Military Adolescent School Based Health Initiative – MASBHI). While we have yet to demonstrate cost-effectiveness from a medical perspective, the program is enormously popular with

parents and schools and has yielded improved immunization rates and other quality measures.

The Pacific Northwest and Madigan will be the pilot site for the new DoD electronic health record. While we have a great deal to do before we bring the new system on line, the end state will almost certainly improve the efficiency of our providers to see patients and enhance our access.

Madigan just opened a new residential treatment facility for substance abuse with our first patients arriving on 1 February, 2016; we broke ground recently on an Intrepid Spirit traumatic brain injury center provided by the Intrepid Fallen Heroes Fund as well as a new Fisher House. We coordinate closely with the Seattle VA and our local VA Center at American Lake where we provide much of the VA's in-patient and specialty care locally. We continue to consider innovative solutions to ensure we provide the very best care to our patients while we prepare our staff to serve our nation in the most difficult environments.

CONCLUSION

Madigan is a tertiary, academic medical center providing the full spectrum of primary and specialty care and serves as the regional referral center for the multi-service market and the Army. I am enormously proud of our 5000 strong Madigan Team and its outstanding reputation in the military and civilian community for health care leadership and professional excellence, our culture of innovation and relentless focus on our patients as the foundation for our improvement activities as well as our recent significant achievements measures of clinical quality, safety, and financial performance.

I am personally committed to improving the readiness of our Soldiers, medical and non-medical alike, so they can best defend America's freedoms and improve the chances that each and every one returns home safely. On behalf of the Madigan Army Medical Center Team and Army Medicine, I want to thank the Army and the Department's senior leaders as well as members of Congress for their continued support.

Colonel Michael L. Place
Commander of Madigan Army Medical Center

Colonel Michael L. Place assumed command of Madigan Army Medical Center on July 15, 2015. His previous assignment was the senior medical advisor in the Army Secretariat, assigned as the Assistant Deputy for Health Affairs in the Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs).

Colonel Place entered the Army as the Distinguished Military Graduate from Johns Hopkins University where he was also recognized as a George C. Marshall Award recipient. After medical school at the Uniformed Services University of the Health Sciences, he completed his internship and family medicine residency as chief resident at Martin Army Community Hospital, Fort Benning, Ga.

His military assignments include regimental surgeon for the 75th Ranger Regiment, deploying to Operation Uphold Democracy in Haiti; staff family physician, Evans Army Community Hospital, Fort Carson, Colo.; commander, Medical Task Force 10, Stabilization Force 5, during the Kosovo Air Campaign; instructor and director, medical operations branch, Leader Training Center, Army Medical Department Center and School where he became the first physician director of the Army Medical Department captains career courses, Fort Sam Houston, Texas; 101st Airborne Division (Air Assault) Division Surgeon, Fort Campbell, Ky., deploying to Operation Iraqi Freedom; and deputy commander for clinical services, Blanchfield Army Community Hospital, Fort Campbell, Ky. He commanded the 10th Combat Support Hospital, Fort Carson, Colo., that included a year-long deployment to Afghanistan during Operation Enduring Freedom as a medical task force commander. Colonel Place worked briefly at the Department of Defense Medical Examination Review Board after an assignment as the command surgeon, U.S. Army Cadet Command.

Colonel Place is a graduate of the AMEDD officer basic and advanced courses, the Army command and general staff college, and The Dwight D. Eisenhower School for National Security and Resource Strategy.

His awards and decorations, include the Legion of Merit, Bronze Star, Meritorious Service Medal, Army Commendation Medal, Joint Service Achievement Medal and Army Achievement Medal, National Defense Service Medal, Armed Forces Expeditionary Medal, Kosovo Campaign Medal, Afghanistan Campaign Medal, Global War on Terror Expeditionary Medal, Humanitarian Service Medal, Army Service Ribbon, Overseas Service Ribbon and the NATO Medal. Colonel Place has been awarded two Meritorious Unit Commendation Medals and proudly wears the Expert Field Medical Badge, Flight Surgeon and Parachutist Badge. He is a member of the Order of Military Medical Merit.

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

STATEMENT OF

CAPTAIN RICK FREEDMAN, DC, USN

COMMANDING OFFICER
NAVAL HOSPITAL CAMP LEJEUNE

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

SUBJECT:

MISSION OF MILITARY TREATMENT FACILITIES

FEBRUARY 3, 2016

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

Chairman Heck, Ranking Member Davis, distinguished Members of the Committee, thank you for providing me the opportunity to share my perspectives as the commanding officer of Naval Hospital Camp Lejeune (NHCL) as well as the role of military treatment facilities (MTFs) in providing medically ready service members and ensuring an operationally ready medical force. We in Navy Medicine are privileged to care for all those entrusted to our care.

Naval Hospital Camp Lejeune: Mission Ready

I am blessed to serve alongside the men and women of NHCL, which has established itself as a robust medical facility in the region providing outstanding support to the Marine Corps, our local community and across Navy Medicine. Navy Medicine has a unique relationship with the Marine Corps, providing health services support across their operational environments. This means that we have Navy Medicine personnel organically assigned with Marine units, as well as at the hospital. Our importance to the Navy and Marine Corps Team, as well as Eastern North Carolina, cannot be overstated and our contributions are visible in many different ways. The primary reason we exist; however, is to build and sustain the readiness of the operational forces with whom we serve.

For NHCL, readiness takes three major forms:

First: Readiness means that we, those of us who wear the cloth of our nation, are ready at a moment's notice to deploy in support of the Navy and Marine Corps team. Physically, professionally, spiritually, medically and administratively – we as active duty providers are ready at all times to deploy in support of the warfighter. Through the daily delivery of quality medical care and support in a garrison setting, our providers, nurses, therapists, clinicians, technicians and support staff are refining their professional skills and core warfighting competencies. We use the latest technologies in medical simulation training to ensure we maintain currency of skills and are always at the top of our game. Additionally, our location aboard Marine Corps Base

(MCB) Camp Lejeune provides us with unique opportunities to serve alongside our operational medical counterparts to ensure we are not only ready, but already integrated into operational doctrine, protocol and practice. We take pride in the fact that many of our military personnel have deployment experience and they apply their skills to their day to day jobs. Navy Medicine MTFs, including our own, provide that reservoir of forward deployable expeditionary medical support for our Combatant Commanders and play a pivotal role in combat operations. Nowhere is that better understood than aboard MCB Camp Lejeune, where it is common knowledge that no Marine has ever taken a hill without a Navy Corpsman by his or her side. Our exceptional Corpsmen, for whom there is no civilian equivalent, have the distinction of being the most highly decorated rating in the Navy. As a matter of fact, 19 of 22 Corpsmen who received the Medal of Honor served with Marines.

The over 600 Corpsmen at NHCL understand their role and are committed to living up to this covenant. Over the past 15 years of combat, our operational forces have experienced the highest battlefield survivability rate ever recorded in history. Navy Medicine and our partners throughout the MHS are committed to preserving this standard and building upon that commitment.

Second: Readiness means that we ensure the Marines and Sailors of II Marine Expeditionary Force (MEF), Marine Special Operations Command (MARSOC) and those assigned to Marine Corps Installations - East are medically ready to be the first to fight in any theater of operation. As mentioned earlier, while Marines do have embedded medical resources, NHCL provides important specialty and surgical support that enable their warfighters to maintain the highest state of medical readiness. We understand their mission requirements and we ensure that we are staffed and equipped to meet their needs. Our hospital leadership collaborates with commanders at every level of II MEF and is aligned in support of MARSOC's Preservation of the Force and

Family program. Several of the hospital's Branch Health Clinics located around the base are staffed jointly with medical personnel from the hospital and providers assigned to the operational units around the base as we bring Marine Centered Medical Home concepts into action. This initiative is designed to improve access, continuity and quality of care for active component forces in garrison. Two additional Interim Marine-Centered Medical Homes will begin operations this summer supporting Marines and Sailors of II Marine Division.

To further ensure all of our providers are ready, NHCL has developed and implemented training programs and educational symposiums for assigned operational providers, and jointly, our medical teams work together in the field as well as in garrison. And most importantly, our operational forces know that NHCL stands ready to be there should additional resources be required. Since my time in Command, our staff has expertly responded to two mass casualty situations following training mishaps. We were on scene as soon as needed to mitigate the loss of life and respond to injuries. This level of readiness and response could not have been replicated by any civilian medical infrastructure currently in existence in our local area. Our mass casualty system was activated and in place within minutes and despite the late hour of the evening in both instances, our Corpsmen, residing in barracks right on our campus, arrived in force before the first casualties were even transported to our facility. It is what we train for. On an associated but equally important note, we have also established a quick Response Mental Health Team that has deployed to support units and individuals impacted by traumatic events such as these. This joint Mental Health/Spiritual Wellness team is locally available and understands the organization and the mission of the impacted unit/individual.

Third: At NHCL, our team understands that taking care of families directly impacts the readiness of the Sailors and Marines stationed at MCB Camp Lejeune. We know whether

delivering babies or setting the broken arm of a child, both contribute to our ability to provide exceptional care to those serving our nation. Family readiness impacts force readiness.

We are committed to quality, safety access and service. Like all of the MHS, we actively collaborated with the Partnership for Patients initiative, implementing best practice protocols to increase patient safety and prevent hospital acquired conditions. Through these collaborative efforts, we improved quality indicators throughout our facility and reduced readmission rates by 31 percent since inception. To reduce the risk of Unintended Retained Foreign Objects during surgery, we've also introduced Radio-frequency Identification (RFID) technology into the OR. Radio frequency identified sponges have been implemented and these objects are identified passively with the use of a "wand" in the OR, and, alert staff to retained sponges prior to exit from the OR suite.

Access to care is also at the forefront of what we do and we at NHCL are making sure our families can get the care they need, day and night, seven days a week, 365 days a year. We are also aware that with changing patient demographics and generational expectations, the nature of how our patients may want to access care has also changed. We are proud to be among the leaders at meeting this new demand for access and communication.

NCHL providers are enthusiastic users of the secure patient-provider electronic communication application that our beneficiaries can use to conveniently exchange emails with their Medical Home Port health care team, to follow up about an appointment, discuss concerns or just to connect with their provider whenever the need arises.

Our team at NHCL has developed an innovative patient Smartphone application that has been the most frequently downloaded in Navy Medicine and provides one centralized portal for our patients to connect and make appointments, get lab results, check availability and refill prescriptions. NHCL is also very proud to have been nominated and approved as the first MHS

site for the White House Social and Behavioral Sciences' efforts to support Secure Messaging expansion. This team under the National Science and Technology Council and chaired by the Assistant to the President for Science and Technology, has partnered with NHCL to develop research protocols to gather data and analyze the use of secure messaging and demonstrate its efficacy in improving patient satisfaction and quality outcome metrics.

NHCL delivers the third most number of babies in Navy Medicine and is proud to note that we have implemented the “Centering in Pregnancy” program that offers group Pre-Natal Care to our patients. This innovative care model, which follows all guidelines from the American Congress of Obstetricians and Gynecologists, offers mothers-to-be a unique, supportive atmosphere that: promotes education, focuses on peer group connections and has been extremely popular with many of our patients, particularly those lacking built-in support systems due to geographic isolation, a deployed spouse or other challenges associated with military service. According to The Centering Healthcare Institute, NHCL, with 27 active Centering groups, has the highest number of participants compared to any other facility in the nation. We are also one of the few MTFs offering Maternal Fetal Medicine specialty care and an embedded Level II Neonatal Intensive Care Unit. Bottom line: Taking care of families impacts readiness and our families enable us to be the most capable military force in the world. We will continue to strive at improving our care and service for every patient, every day. Our families deserve nothing less.

The Navy Medicine enterprise, like the rest of the MHS, is committed to becoming a High Reliability Organization (HRO) emphasizing quality outcomes, patient safety and a robust process improvement system supported by leadership. This shift from health care to health is perfectly suited for the MHS, where we practice as an integrated care enterprise that can focus on healthy outcomes and evidenced-based treatments. I am extremely proud to note that at NHCL,

we took a page from The Joint Commission Center for Transforming Healthcare and begin each day with a focus on quality and patient safety. Our entire Board of Directors meets each morning to discuss any safety concerns that may have occurred in the past 24 hours, and any safety concerns which could potentially affect patient care in the next 24 hours. This commitment to quality and environment of collaboration, similar to what is happening at many other institutions across the MHS, has allowed our organization to move above many nationally-recognized quality and safety benchmarks while maintaining an extremely high patient satisfaction rating. Most importantly, since our system of remuneration is not about profit, it allows us to uniquely focus on the most important thing - the next patient that walks into our facility.

It is critical to note the importance of NHCL, given our location in Eastern North Carolina, has become a leader in quality, safety, education, training and research and play a critically-important role in a medically-underserved area of our country. We have wonderfully talented and dedicated civilian medical partners in Jacksonville and the surrounding areas, who are truly committed to our Marines and their families; however, our community does not have the medical infrastructure which may exist in other metropolitan areas. Our closest trauma center is 90 minutes away and some specialty and subspecialty care is not easy to access in this area. Our Managed Care Support Contractor, which is responsible for coordinating the civilian health network of providers to support our military families, fully understands our importance here and has indicated there is no way this region could absorb and support the medical demand without our hospital.

Navy Medicine realized the need for improvements in the specialty care provided at NHCL and following the CONUS Hospital Optimization plan, realigned resources to better suit the existing and emerging missions, as well as made adjustments based on what the civilian medical

community could support. Consequently, over the past two years, NHCL significantly increased in size, capacity and capability.

NCHL's capabilities have simultaneously grown through the increased integration of technology. We have launched a Tele-ICU project virtually connecting our Intensive Care Unit directly with Naval Medical Center San Diego, allowing their team to digitally collaborate with our providers ensuring real time assessment, consultation and critical care support. Through digital radiology, we are able to move images and not patients, instantaneously transmitting images between our many Branch Health Clinics, our main hospital and specialists and sub-specialists at Naval Medical Center Portsmouth. Integrating Tele-Pharmacy has also allowed us to maintain the highest levels of quality and service at multiple pharmacies located across the 246 square miles of the base.

We have also become leaders in combat-related research making real battlefield differences with 25 current research protocols and 18 active institutional collaborations. We have expanded our pain management services, which not only serve the health needs of our beneficiaries, but also allow for the coordination and management of complex poly-pharmacy cases, while mitigating the possibility of medication abuse. Our pain management case manager identifies high utilizers through a monthly review of the Controlled Drug Management and Analysis Reporting Tool (CDMART) provided by the DHA's Pharmacoeconomic Center. Patients who are identified as having chronic pain and potential drug misuse/abuse are then referred to the pain clinic for comprehensive management to include: (1) sole provider agreement; (2) periodic urine drug screening for controlled substance compliance monitoring; and, (3) assigning a TRICARE prescription restriction form to limit member to receiving controlled substances from the MTF pharmacy for monitoring. NHCL staff collaborates with II MEF medical officer assets to make them aware of their high-risk active duty members as well. NHCL is uniquely prepared

to meet the mental health needs of our operational forces, with over 60 licensed independent mental health professionals and a 20-bed inpatient mental health unit. We recently opened the first sleep medicine center in this region.

Our Graduate Medical Education (GME) programs are a vital training base for Navy Medicine. If they are no longer available, it would be difficult to re-establish that lost capability. Our teaching program at NHCL, indicative of others throughout Navy Medicine, is a robust, dynamic institution, offering unique training opportunities in military medicine and research. It has received the highest level of certification by the Accreditation Council for Graduate Medical (ACGME) Education and has achieved an unprecedented 100 percent board pass rate for our residents for four consecutive years. As previously discussed, the realignment of resources to meet mission requirements has led to the expansion of our Family Medicine Residency program by 50 percent and our growth has occurred simultaneously with more than 30 percent increase of our enrolled patient population, to include a doubling of our enrolled retired beneficiaries. Their re-affiliation with our hospital has the dual benefit of improving the acuity and complexity of cases for our interns, residents and specialists, while more importantly, allowing our team to care for those who have previously served and who are deserving of best this nation can offer.

One of the most unique aspects of NHCL is also one of the most effective. Our Intrepid Spirit Concussion Recovery Center, which has no counterpart in the civilian health care setting, is part of the National Intrepid Center of Excellence network. Our Center offers exceptional care and support of our warfighters afflicted with traumatic brain injury (TBI) and uses an innovative patient-centered approach. It is a holistic, integrated, interdisciplinary treatment program that provides care for the warfighter and their families. At the Intrepid Spirit, the providers are organized into teams and co-located in one building. Care is both physically and

organizationally located in one place that is built around the needs of the patients and their families. Teams bring 10 different specialties to the patient, including Neurology, Neuropsychology, Audiology, Physical and Occupational Therapy, Neuro Optometry as well as incorporating Complimentary Alternative Medicine (CAM) techniques.

Care at the Intrepid Spirit Center is tailored to meet the unique needs of these warrior athletes, whose duties require them to be able to perform at a very high level. The emphasis is on rehabilitation and the goal is to return them to the highest level of function possible, with minimal medication use. To help accomplish this goal CAM techniques like yoga, acupuncture, and other non-pharmacological modalities are an integral part of the Intrepid Spirit program. To date, approximately two thousand warfighters have gone through the program, and more than 90 percent of them, at least from the standpoint of TBI, have been returned to full duty.

In summary, we are a critical and integral part of the greatest and most highly-capable Navy and Marine Corps team the world has ever known. Our hospital serves as the readiness platform for the staff assigned to our hospital, the Sailors and Marines stationed in this area, as well as their families. We will continue to provide forward-deployable expeditionary medical capability while maintaining the highest levels of readiness. We appreciate the opportunity to share with you what we do at Naval Hospital Camp Lejeune. We are grateful for your support of military medicine and I look forward to answering your questions.

Captain Rick Freedman
Dental Corps, United States Navy
Commanding Officer, Naval Hospital Camp Lejeune

Captain Rick Freedman, a native of Philadelphia, Pa., attended a combined academic program at the University of Pittsburgh and the University of Pittsburgh School of Dental Medicine, where he graduated in 1991 with a Bachelor of Science degree in Biology and a Doctorate in Medical Dentistry. After graduation, Freedman was commissioned as a Lieutenant in the U.S. Navy Dental Corps. In 2000, he completed residency training at the Naval Postgraduate Dental School, earning a Certificate in Comprehensive Dentistry as well as a Masters Degree in Health Sciences from George Washington University.

Freedman's first assignment was with the 2nd Dental Battalion, 2nd Force Service Support Group in Camp Lejeune, N. C., where he served as Assistant Dental Officer. In 1993, he reported to Recruit Training Command, Naval Dental Center Orlando, Fla. Freedman then transferred to Branch Dental Clinic, Patuxent River, Md. in 1994. In 1998, Freedman attended the Naval Postgraduate Dental School in Bethesda, Md. In 2000, Freedman reported aboard the USS Inchon (MCS 12), homeported in Ingleside, Tex., where he served as Department Head during the ship's final deployment and subsequent decommissioning. In 2002, he served as the director of an American Dental Association accredited Advanced Education in General Dentistry residency program in Jacksonville, Fla. During his tour in Jacksonville, Freedman also served as Director of Branch Dental Clinic Jacksonville, and later as Department Head of Naval Branch Health Clinic Jacksonville. In 2005, he transferred to Naval Branch Health Clinic Atlanta where he assumed the duties of Officer in Charge. In 2007, Freedman reported to Naval Branch Health Clinic Oceana, Va. to assume the role of Officer in Charge, and during his tour deployed aboard USS Boxer (LHD 4) in support of Operation Continuing Promise 2008. In 2009, he was named Director, Primary Care and Branch Health Clinics at Naval Medical Center Portsmouth, Va. In 2012, Freedman was selected to serve as Executive Officer, U. S. Naval Hospital Okinawa, where he oversaw the facility's historic transition to its new location aboard Camp Foster.

Freedman is a Diplomate of the American Board of General Dentistry, Fellow of the Academy of General Dentistry and is a member of both the American College of Healthcare Executives and the Interagency Institute for Federal Health Care Executives. He was one of the original representatives on the Bureau of Medicine and Surgery's Oral Health Advisory Board, and has served as faculty for Navy Medicine Professional Development Center's Clinic Manager's Course.

His decorations include the Meritorious Service Medal (five awards), Navy and Marine Corps Commendation Medal (three awards), Navy and Marine Corps Achievement Medal (two awards), and various service and unit awards.

DEPARTMENT OF THE AIR FORCE
PRESENTATION TO THE SUBCOMMITTEE ON MILITARY PERSONNEL
COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: MILITARY TREATMENT FACILITY (MTF) MISSIONS

STATEMENT OF: COLONEL DOUGLAS M. LITTLEFIELD
COMMANDER, 19TH MEDICAL GROUP
UNITED STATES AIR FORCE

FEBRUARY 3, 2016

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

Chairman Heck, Ranking Member Davis, and distinguished members of the Committee, thank you for the opportunity to come before you today to discuss the role Military Treatment Facilities (MTFs) play in supporting military readiness.

As the commander of the 19th Medical Group at Little Rock Air Force Base, my team of approximately 350 dedicated practitioners are responsible for a population of 44,000 beneficiaries. Roughly 14,000 beneficiaries are enrolled directly to our facility and receive care in our various clinics. This population is composed of about 6,000 active duty members, 5,000 active duty family members and 3,000 retirees and their dependents.

Unlike many civilian outpatient facilities, the 19th Medical Group provides services such as radiology, laboratory, physical therapy, mental health, and dental services. Like most Air Force MTFs, we also have Public and Bioenvironmental Health, a Systems Flight, TRICARE Operations and Patient Administration (TOPA), Medical Management and a Facility Support team.

Our MTF directly supports “Team Little Rock,” which is composed of two active duty wings, a traditional Air National Guard wing and a Reserve Group. The 19th Airlift Wing is part of Air Mobility Command (AMC) and is the host, while the 314th Airlift Wing’s training mission falls under Air Education and Training Command (AETC). These separate entities surge forward to execute, generate and support unrivaled combat airlift...anywhere, anytime!

“Team Little Rock” continues to support our nation’s mission by having deployment-ready Airmen available on a moment’s notice. Over the past 18 months, our base averaged 300-400 Airmen deployed at any given time including 46 medics. We provide all the medical care necessary to ensure our base’s active duty population is ready to deploy, but we, ourselves must also be ready to deploy in relatively short order.

To that end, our primary focus is directed toward the numerous requirements needed to keep our Airmen combat ready. An Airman’s individual medical readiness is contingent upon

staying up-to-date on everything from immunizations, annual preventive health assessments, dental examinations and current laboratory tests. In addition to keeping Airmen from across the wing ready, our medical providers and technicians must find time in the midst of a very busy daily schedule to maintain their clinical currency and readiness training. These activities include hands-on readiness skills verification courses, disaster team training, numerous wing level exercises and continuing medical education.

We have from two to seven medical group members deployed at any given time. In many instances, Airmen require specific medical team training for their deployment that can take them out of the clinic for several weeks before they leave for their deployment. This readiness commitment has an impact on our patient appointment availability and is the single largest delineator between military medicine and civilian healthcare.

Despite the unique readiness challenges we face in military medicine, we average nearly 8,000 appointments across our clinics each month. In addition, we partner with a robust civilian provider

network to offer services we are unable to provide. The current civilian network, managed by Humana, contains 3,300 providers across the spectrum of required services. The network referral demand averages around 1,700 appointments per month.

The most unique skill set we have is our Aerospace Physiology/High Altitude Airdrop Mission Support (AOP/HAAMS) team. As the only provider of this service in the Department of Defense (DoD), this highly trained cadre of Airmen support Special Operators from all Services, DoD agencies, and allied nations. They train aircrew and Special Operators to recognize the signs and symptoms of hypoxia and decompression sickness in unpressurized environments which could have serious negative effects on the members involved. They also directly support missions involving unpressurized aircraft between 10,000 and 35,000 feet in altitude, and are required for missions above 20,000 feet.

Unquestionably, the pharmacy sees the most beneficiaries each day. They fill 1,100 prescriptions from in-house and off-base

providers each day. As the only active duty clinic in Arkansas, patients travel from areas all over the state to use our pharmacy. We are fortunate to have 35 civilians who volunteer to work in our pharmacy each week. Many are retired military members who still serve by donating their time and very positive attitudes while taking care of our pharmacy patients. Without these volunteers, our staff would be unable meet the demand of our beneficiary population.

The October 1, 2015, changes in the TRICARE prescription benefit requiring all non-active duty members to refill medication through military pharmacies (i.e., on-base) or through TRICARE's Home Delivery service, has increased prescription demand 8-10% compared to the same period last year. Even with educating our beneficiaries about the mail-order option to have refilled medications sent to their front door, our population reports enjoying the social experience of coming to the base where they can also take advantage of other benefits, such as the Commissary and Base Exchange. However, because of this we have wait times.

To alleviate this congestion, we are working with our local wing leadership and the Air Force Health Facilities Division to find a solution to further improve the pharmacy service we provide our beneficiaries.

At the end of the day, the medical group's primary mission is to ensure medically fit Airmen and ready medical Airmen to accomplish the wing's readiness mission when called upon. I have three priorities that keep my team focused: mission, people and communication. Mission is our first priority. It is the reason we exist and what we pour our daily efforts into. Our team is a vital part of Combat Airlift providing exceptional care, support and service to our patients and we continually look for the most efficient ways to accomplish this. The effort we put in each day is focused on promoting teamwork at all levels. Our mindset is to utilize the strengths each team member brings to form a cohesive unit while working together to solve the challenges we encounter.

Second, our people are a priority. Our amazing teammates are how we get the mission done and treat our patients, family

members, community partners and each other with the utmost respect and professionalism. We are committed to staying resilient in all areas of our lives, which makes us more productive and better team members to those around us. We also look for opportunities within the MTF, wing and community to grow personally and professionally to become better Airmen.

Our final priority is communication. There is no substitute for clear, concise communication at all levels, which allows our team to function at its peak. We are always seeking opportunities to improve our communication methods by listening more than we speak to include utilizing different sources of information across available spectrums to get pertinent messages to those we support.

In conclusion, it is truly an honor to lead the 19th Medical Group team. I am continually impressed by my team's efforts to serve our beneficiaries while taking care of each other in the process. It is a worthy calling and one we do not take lightly.

I am grateful for the opportunity to appear before you today and look forward to your questions.

Colonel Douglas M. Littlefield, USAF
Commander, 19th Medical Group, Little Rock Air Force Base

Colonel Douglas M. Littlefield currently serves as the Commander, 19th Medical Group, Little Rock Air Force Base, Arkansas. He assumed command on 11 July 2014. Colonel Littlefield oversees the delivery of healthcare services to nearly 44,000 eligible beneficiaries in central Arkansas and 14,000 beneficiaries enrolled in TRICARE Prime. He serves as chief executive officer for an outpatient, primary care clinic offering flight medicine, family practice, pediatrics, optometry, dental care, a broad range of diagnostic and therapeutic capabilities as well as health and wellness services. He advises the 19th Airlift Wing and 314th Airlift Wing Commanders on all medical matters

Col Littlefield entered the Air Force after graduating from the University of Texas Health Science Center Dental School in San Antonio in 1994 and 6 years of private practice in Sugar Land, Texas. He has been married to the former Sharon Kaye King of Denton, Texas for the past 20 years and they currently have four children, Savannah (19), Carson (17), Riley (15) and Ainsley (13).

EDUCATION:

1987-1990: BA in Biology, Austin College - Sherman, TX
 1990-1994: Doctor of Dental Surgery, Univ. of Texas Health Science Center - San Antonio, TX
 2001 Jan: Commissioned Officer Training, Maxwell AFB, AL
 2002: Squadron Officer School (Correspondence)
 2004: Air Command and Staff College (Correspondence)
 July 2004 - July 2005: Advanced Education in General Dentistry Residency, Offutt AFB, NE
 2006: Intermediate Executive Skills Course, Sheppard AFB, TX
 2009: Air War College (Correspondence)
 2014: Interagency Institute for Federal Healthcare Executives

ASSIGNMENTS:

Feb 2001 - July 2004: General Dentist, 435th Dental Squadron, Ramstein AFB, Germany
 July 2004 - July 2005: General Dentistry Resident, 55th Dental Squadron, Offutt AFB, Omaha, NE
 Aug 2005 - July 2007: Chief, Dental Services, Andersen AFB, Guam
 Aug 2007 - May 2011: Dental Support Programs Manager, AFMOA, San Antonio, TX
 May 2011 - June 2013: Commander, 377th Dental Squadron, Kirtland AFB, Albuquerque, NM
 June 2013 - July 2014: Deputy Group Commander, 31st Medical Group, Aviano AB, Italy
 July 2014 - Present: Commander, 19th Medical Group, Little Rock AFB, AR

MAJOR AWARDS AND DECORATIONS:

1. Meritorious Service Medal (3 oak leaf clusters)
2. Air Force Commendation Medal
3. AF Outstanding Unit Award (5 oak leaf clusters)
4. AF Organizational Excellence Award
5. National Defense Service Medal
6. Global War on Terrorism Service Medal
7. Nuclear Deterrence Operations Service Medal (1 oak leaf cluster)
8. AF Overseas Ribbon Short
9. AF Overseas Ribbon Long
10. AF Longevity Service (2 oak leaf clusters)
11. Small Arms Expert Marksmanship Ribbon (Pistol)
12. AF Training Ribbon

PROFESSIONAL AFFILIATIONS:

American Dental Association - Member
Academy of General Dentistry – Fellow
Interagency Institute for Federal Healthcare Executives - Member

EFFECTIVE DATES OF PROMOTION:

Captain 6 Dec. 2000
Major 6 Dec. 2003
Lt Col 6 Dec. 2009
Col 27 May 2014

(Current as of 1 Jan. 2016)

**WITNESS RESPONSES TO QUESTIONS ASKED DURING
THE HEARING**

FEBRUARY 3, 2016

RESPONSE TO QUESTION SUBMITTED BY DR. HECK

Colonel PLACE. Prior to 1995, no Level 2 trauma centers supported Tacoma and Pierce County. All major trauma victims were transported to Seattle, Washington or Portland, Oregon. In 1995, Madigan Army Medical Center (MAMC), was approved and received full Washington state designation as the only Level 2 trauma center serving the Tacoma area. From 1997–2000, MAMC worked with civilian health systems to establish civilian Level 2 trauma centers in Tacoma. The Tacoma Trauma Trust was formed in 2000 and established two civilian Level 2 trauma centers to serve Tacoma and Pierce County. Trauma duties are split between two civilian hospitals, St. Joseph Medical Center and Tacoma General Hospital, alternating coverage every other day. MAMC accepts trauma patients every day. [See page 9.]

RESPONSE TO QUESTION SUBMITTED BY MR. MacARTHUR

Captain FREEDMAN. Thank you for your question and the opportunity to provide additional information. One of the key components of readiness is to ensure that we hone, train and sustain the clinical skills of our providers. An important element of that strategy is ensuring we have the right mix of patients with the appropriate level of medical complexity to maintain the currency of skills for our entire clinical staff. To help achieve this at Naval Hospital Camp Lejeune, we focused on the enrollment of our eligible retired and retiree family member beneficiaries.

Our multi-phased recapture efforts began with a concentrated and sustained informational exchange campaign outlining our strategy. Our team employed multiple information pathways to include our command's Facebook page, Marine Corps Community Services and Base website releases, Family Readiness Office exchanges and community media outlet notifications to inform our retiree population of our plan and solicit their partnership. Our hospital is an active and pivotal part of our community and my leadership team and I participated in multiple events to encourage retiree participation and enrollment. These events occur throughout the year and included retiree town halls, the annual retiree appreciation fair, Regiment of Retired Marines Breakfast, Disabled American Veterans Gatherings, USO/VFW events, Chamber of Commerce, Military Affairs Committees meetings, and regional TRICARE benefit briefings.

On the administrative front, we directed policy changes to open enrollment to the retiree population within a 30 minute drive time to Camp Lejeune. We focused on service members and families transitioning from active duty and automatically enrolled all who selected TRICARE Prime and resided within the Prime Service area, or PSA. Additionally, we invited retirees currently receiving care in the network to change their enrollment to NH Camp Lejeune, sending a retiree invitational letter to 7,702 eligible beneficiaries in the PSA.

As a direct result of these efforts, we have had a 100 percent increase in the number of enrolled retiree and retiree family members, growing from 3,861 in January 2014 to an all-time high of 7,891 enrollees as of January 2016. Through this re-engagement, we have been able to meet our commitment to ensuring the readiness of our medical staff, attracting and retaining the best clinicians while expanding our clinical capability and service to the operational forces assigned to Marine Corps Base Camp Lejeune and the local community. Perhaps most importantly, we have re-affirmed our commitment to serving the most deserving men and women in the world, those who have worn the cloth of our nation and the families who support them. [See page 25.]